

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019587

STATE FILE NUMBER

FILED JUN 4 1959

Registration District No.

Primary Registration District No.

Registrar No. 5025

300

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hosp.		Length of stay in 1b 1 week	d. STREET ADDRESS 3527 S. 2nd St.
3. NAME OF DECEASED (Type or print) First Michael Middle Last Sahagian			4. DATE OF DEATH Month 5 Day 22 Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1879
10a. USUAL OCCUPATION (Enter only one cause per line for (a), (b), and (c.) during most of working life, even if retired) Retired Molder		10b. KIND OF BUSINESS OR INDUSTRY --	9. AGE (In years last birthday) 79
11. BIRTHPLACE (City and state or country) Armenia		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown Sahagian		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Pearl		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Pearl Sahagian Address 3527 S. 2nd St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 523.0 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 5-14-59 to 5-22-59 and last saw her/him alive on 5-22 Death occurred at 1:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John Withers MD (Degree or title)		22b. ADDRESS 5600 S. Compton	22c. DATE SIGNED 5-23-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/25/59	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR WACKER-HELDERLE ADDRESS 3634 Gravois		25. DATE RECD. BY LOCAL REG. MAY 25 '59	REGISTRAR'S SIGNATURE Earl Smith. M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Delis J. Krupin*
Licensed Embalmer No. *3497*
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.