Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019588
STATE FILE NUMBER

FILED JUN 11 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 5179

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST.LOUIS,MO. Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St.Louis Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST.LOUIS CITY HOSP. #1. Length of stay in lb 0	d. STREET ADDRESS (If outside, give location) 3309 Oregon Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last SANDBERG

4. DATE OF DEATH Month Day Year MAY 29,1959

5. SEX Male 0

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 0

8. DATE OF BIRTH March 10,1879

9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.Insurance Agent

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Sandberg

13b. MOTHER'S MAIDEN NAME M.Loeffel

14. NAME OF HUSBAND OR WIFE -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. unknown

17. INFORMANT Mrs.Ralph Abbatiello Address 901 Wilmington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 18 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerosis — Years

DUE TO (c) Arteriosclerotic Heart Disease — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Prostatic Hyperplasia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 420.0

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 4/16/59, to 5/29/59 and last saw her/him alive on 5/29/59

Death occurred at 6:50 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John F. Clisham MD 0

22b. ADDRESS 1515 LAFAYETTE AVE

22c. DATE SIGNED 5/29/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 6-2-59

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) (State) St.Louis,Missouri

24. FUNERAL DIRECTOR Southern F.Home ADDRESS 6322 S.Grand Blvd.

25. DATE RECD. BY LOCAL REG. MAY 29 '59

26. REGISTRAR'S SIGNATURE Earl Smith, M.D. MDL

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 David Alan Fossum

Licensed Embalmer No. 4242

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.