

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-017706

FILED VS APR 29 1960

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 1068

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland		Length of stay in 1b 3 yrs.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O'Sullivan Nursing Hme.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7225 Minerva Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) MISS MABEL LAURA SAGE			4. DATE OF DEATH Month March Day 28 Year 1960			
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5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1876	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Ringer's delicatessen		11. BIRTHPLACE (City and state or country) Beardstown, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME David S. Sage	13b. MOTHER'S MAIDEN NAME Henrietta Holly	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. 498-09-2428	17. INFORMANT Mrs. Christensen	Address 7490 Amherst Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombus aortic bifurcation DUE TO (b) Thrombosis left iliac artery 4/200 DUE TO (c) Arteriosclerotic Heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerosis generalized		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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 Winchester	COUNTY Illinois	STATE
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21. I attended the deceased from March 12, 1959 to March 28, 1960 and last saw her alive on 3-28-60 Death occurred at 6:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Lewis Lillmann MD	22b. ADDRESS 8231 Clayton Rd (17)	22c. DATE SIGNED 3-30-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Auto	23b. DATE 3/31/1960	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) Winchester	(State) Illinois
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24. FUNERAL DIRECTOR Alexander & Sons	ADDRESS 6175 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. 3-30-60	26. REGISTRAR'S SIGNATURE John C. Murphy MD.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Lewis E. Littman
8231 Clayton Rd.,
PA7-0202

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Joseph E. McCallister

Licensed Embalmer No. 297

P. O. Address 2175

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.