RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

60-024925
STATE FILE NUMBER

NDED

FILED VS JUL 1 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6117

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. John's Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 6448 Smiley Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: EMMA Middle: D. Last: SAEBENS
4. DATE OF DEATH: Month: June Day: 15 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-29-1909
9. AGE (last birthday): 50
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Dixon, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: George Duncan
13b. MOTHER'S MAIDEN NAME: Emma Carter
14. NAME OF HUSBAND OR WIFE: Warner Saebens
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 493-20-0279
17. INFORMANT: Warner Saebens Address: 6448 Smiley 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): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of Lung
DUE TO (c): 163X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Secondary Anemia, ? Cerebral Metastasis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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

BY AFFIDAVIT OF

21. I attended the deceased from 6-16-59 to 6-15-60 and last saw her/him alive on 6-14-60
Death occurred at 5:30 A.M. 4:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Joseph V. O'Donnell M.D. (Degree or title)
22b. ADDRESS: 5391 N. Grand - St. Louis 3, Mo.
22c. DATE SIGNED: 6/15/60
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: June 17, 1960
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS: Kriegshauser 4228 S. Kingshighway Blvd.
25. DATE RECD. BY LOCAL REG.: JUN 15 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Geo. H. Kriegshauser, Jr.

Signature of Student Embalmer

Licensed Embalmer No. 4988

P. O. Address St. Louis,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor
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.