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FILED MAR 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4237

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 69

1. PLACE OF DEATH  
a. COUNTY Cape Girardeau

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau

c. LENGTH OF STAY (in this place) 28 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION South East Mo Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE Missouri b. COUNTY Cape Girardeau

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gordenville Mo

d. STREET ADDRESS (If rural, give location) \_\_\_\_\_

3. NAME OF DECEASED  
(Type or Print) a. (First) William Henry c. (Last) Sachse

4. DATE OF DEATH (Month) (Day) (Year)  
Mar 8 1949

5. SEX M

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower

8. DATE OF BIRTH April 26 1868

9. AGE (In years) (Month) (Day) 80 10 12

IF UNDER 1 YEAR (Hours) (Min.)

10a. USUAL OCCUPATION (Give kind of work and classification of work) Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (State or foreign country) Old Appleton Mo

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Henry Sachse

13b. MOTHER'S MAIDEN NAME Josephine Gross

14. NAME OF HUSBAND OR WIFE Rosena Schwoer SACHSE

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. \_\_\_\_\_

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Otto Sachse Oak Ridge Mo

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
  
\*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Anemia

ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) Chronic nephritis  
DUE TO (c) \_\_\_\_\_

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death. Anemia

INTERVAL BETWEEN ONSET AND DEATH 3 hrs  
unknown

19a. DATE OF OPERATION \_\_\_\_\_

19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) \_\_\_\_\_

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) \_\_\_\_\_

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) \_\_\_\_\_

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from 2-11, 1949, to 3-8, 1949, that I last saw the deceased alive on 3-8, 1949, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. F. McDonald, M.D.

23b. ADDRESS Jackson, Mo.

23c. DATE SIGNED 3-9-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE March 10 49

24c. NAME OF CEMETERY OR CREMATORY Zion Lutheran

24d. LOCATION (City, town, or county) (State) Cape Girardeau Co. Mo

DATE REC'D BY LOCAL REG. March 10-49

REGISTRAR'S SIGNATURE C. C. Summers

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. E. Conroy 4440 Jackson Hwy

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FIVED

Health Officer No. 4

Number 349-350

3-14-49

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 .....  
Student Embalmer

Signed

*Bill Meyer*

Licensed Embalmer No.

3057

P. O. Address

Jackson MO

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