THE DIVISION OF HEALTH OF MISSOURI

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STANDARD CERTIFICATE OF DEATH

State File No. 10265

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis State Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 3327 S. Jefferson

3. NAME OF DECEASED (Type or Print): a. (First) AUGUST b. (Middle) c. (Last) SANDERMANN

4. DATE OF DEATH (Month) (Day) (Year): Nov. 28, 1949

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 12, 1886

9. AGE (If years last birthday): 63
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): Retired

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: August Sandermann

13b. MOTHER'S MAIDEN NAME: Dora Dumeyer

14. NAME OF HUSBAND OR WIFE: Barbara

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.: ---

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Barbara Sandermann--3327 S. Jefferson

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) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1937x

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

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

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): 99
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: H570

22. *I hereby certify that I attended the deceased from* May 12, 1947, *to* Nov. 28, 1949, *that I last saw the deceased alive on* Nov. 28, 1949, *and that death occurred at* 1:25p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. Hollaller M.D.
23b. ADDRESS: 5400 Arsenal St.
23c. DATE SIGNED: 11/28/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/1/49
24c. NAME OF CEMETERY OR CREMATORY: St. Pauls Churchyard
24d. LOCATION (City, town, or county) (State): St. Louis Co., Missouri

DATE REC'D BY LOCAL REG.: NOV 29 1949
REGISTRAR'S SIGNATURE: J. B. Fassaten
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wacker-Weilerte 3634 Gravois

(Licensed Embalmer's Statement on Reverse Side)

I hereby declare that this certified copy is an exact photo-static reproduction of the certificate for the person named therein, as it now appears in the permanent records of the Bureau of Vital Statistics, Division of Health of the City of St. Louis. Witness my hand as City Registrar and the Seal of the Division of Health of said City this date- JUL 8 '53

Earl Smith M.D. Per B 18678

City Registrar

DO NOT ACCEPT IF altered, Rephotographed, or if seal impression cannot be felt.

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