S. No. 2
M—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 26 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 25770

Registrar's No. 6863

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: MALCOM BLISS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 4608 DELMAR BL.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SADY LARSON
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife EDWARD
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased DEC. 18 1895 (Month) (Day) (Year)

8. AGE: Years 51 Months 7 Days 3 If less than one day hr. min.

9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business

MOTHER FATHER
12. Name JOSEPH ENDICOTT
13. Birthplace ARK. (City, town, or county) (State or foreign country)
14. Maiden name RACHAEL KEESE
15. Birthplace OHIO (City, town, or country) (State or foreign country)

16. (a) Informant Mrs Lucy Endicott
(b) Address 4608 Delmar Bl.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7/24/47 (Month) (Day) (Year)
(c) Place: burial or cremation POTOSI, MO
18. (a) Signature of funeral director L. Mullen Und. Co
(b) Address 5165 Delmar Bl.
19. (a) JUL 27 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21st year 1947 hour 8:15 minute A M.
21. I hereby certify that I attended the deceased from 5/21/47, 19..., to July 21st, 19 47 that I last saw him alive on July 21st, 19 47 and that death occurred on the date and hour stated above.

Immediate cause of death: Psychosis with CNS lues — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] M.D.
Address 1515 Lafayette Date signed 7/21/47

Jefferson City Printing Co.

(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 me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.