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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 23 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34652**
Registrar's No. **8873**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis,**
(b) City or town **St. Louis,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3908 Chippewa Ave.,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **San**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3908 Chippewa Ave.,**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **PEARL ETTA SAWYER.**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Chester A. Sawyer.** 6. (c) Age of husband or wife if alive **64** years
7. Birth date of deceased **June 24, 1882.**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **12**
year **1948** hour **5:45** minute **P.** M.
21. I hereby certify that I attended the deceased from **June 1, 1948**
Oct 12, 1948 to **Oct 12, 1948**
that I last saw her alive on **Oct 12, 1948**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
66. **3.** **18.** hr. min.

Immediate cause of death
Cerebral apoplexy Duration **1 day**
Due to **Alzheimer's**
respiratory disease 5 yrs
Due to **arteriosclerosis**
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace **St. Louis, Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____
12. Name **William Shear.**
13. Birthplace **Tennessee.**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown.**
15. Birthplace **Tennessee.**
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mr. Chester A. Sawyer.**
(b) Address **3908 Chippewa Ave.,**
17. (a) **Burial.** (b) Date thereof **10/15/48.**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Trinity Cemetery.**
18. (a) Signature of funeral director **C.R. Lupton & Sons.,**
(b) Address **7233 Delmar Blvd.**
19. (a) **OCT. 13 1948** (b) **J. B. Lasater**
(Date received local registrar) (Registrar's signature)

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?
While at work? _____ (Specify type of place) (f) Means of injury _____
23. Signature **Richard M. Smith** (M. D. or other) **MS**
Address **445 So. Grand** Date signed **10/13/48**

Grand & Merriam
P.L. 9650
11-12

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 Clarence H. Murray
Licensed Embalmer No. 401
P. O. Address St. Louis, 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.