

FILED JUL 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25620

BIRTH NO.		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. 1624	
1. PLACE OF DEATH a. COUNTY ST LOUIS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE MISSOURI b. COUNTY ST LOUIS			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BEL-RIDGE		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BEL-RIDGE		4190	
3. FULL NAME OF HOSPITAL OR INSTITUTION 3214 MAYBELLE DRIVE				d. STREET ADDRESS (If rural, give location) 3214 MAYBELLE DRIVE			
3. NAME OF DECEASED (Type or Print) SARAH		fa. (First) KATHERINE		c. (Last) DAVIS		4. DATE OF DEATH (Month) (Day) (Year) JUNE 29 1950	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH MARCH 28 1869	
9. AGE (in years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) HAZEL PATCH, KY	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME THOMAS YOUNG		13b. MOTHER'S MAIDEN NAME MARY ELIZABETH ARTHUR		14. NAME OF HUSBAND OR WIFE WILLIAM DAVIS (DCD)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME ADDRESS LOUIS B. DAVIS 3214 MAYBELLE DRIVE			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Transition - Senility INTERVAL BETWEEN ONSET AND DEATH 4-4-50 ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fracture of left femur - 79 DUE TO (c) Amputation of leg - June 29-50 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility - accident - 4/4/50					
19a. DATE OF OPERATION April 1950		19b. MAJOR FINDINGS OF OPERATION Fracture left femur 903.0				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21c. (CITY, TOWN, OR TOWNSHIP) ST LOUIS (COUNTY) 21 (STATE) MO		21d. TIME OF INJURY 4-4-1950	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fall in house		89050			
22. I, hereby certify that I attended the deceased from 4-4-1950, to 6-29-1950, that I last saw the deceased alive on 6-29-1950, and that death occurred at 4:55 p.m., from the causes and on the date stated above.							
23a. SIGNATURE U (Degree or title)				23b. ADDRESS 6121 Eastern Ave. St. Louis		23c. DATE SIGNED 7-1-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) OUBIARD		24b. DATE 7-9-50		24c. NAME OF CEMETERY OR CREMATORY LATE CHARLES PARK		24d. LOCATION (City, town, or county) WELLSBTON MISSOURI	
DATE REC'D BY LOCAL REG. 7-3-50		REGISTRAR'S SIGNATURE Herbert G. Wombe		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BAUMANN BROTHERS OVERLAND, MO.			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *Oscar F. Mueller*

Signed.....
Student Embalmer

Licensed Embalmer No. *3039*

P. O. Address *Oakland, N.Y.*

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.