

S. No. 300
V. 10.48

FILED NOV 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35191
State File No. 3351
9351
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) WARE	
c. LENGTH OF STAY (in this place) 6 wks.		d. STREET ADDRESS (If rural, give location) Gen'l Delivery	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) SARAH b. (Middle) Elizabeth c. (Last) Huskey			4. DATE OF DEATH (Month) (Day) (Year) 10-21-51		
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH April 6, 1865		9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) Jefferson Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home			

13a. FATHER'S NAME FRANCIS Campbell		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE JOHN E Huskey	
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. None		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Adolph Eaton Ware, 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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture L. Hip		INTERVAL BETWEEN ONSET AND DEATH 6 wks.
	2. PRECEDENT CAUSES (b) Arteriosclerotic heart disease		
	3. OTHER SIGNIFICANT CONDITIONS (c) Bronchopneumonia		
	4. 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 <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, (COUNTY) (STATE) Wats (MO)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 1951 m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fall	

22. I hereby certify that I attended the deceased from Aug 1951, to 10/21/51, 1951, that I last saw the deceased alive on 10/20, 1951, and that death occurred at 11 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Deaconess Sawe MO		23b. ADDRESS 634 N. Grand Ave		23c. DATE SIGNED 10/23/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) 4		24b. DATE 10-24-51		24c. NAME OF CEMETERY OR CREMATORY WARE	
				24d. LOCATION (City, town, or county) (State) WARE MO	

DATE REC'D BY LOCAL REG. OCT 23 1951		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Lee Mathershead, Wats, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

1788
170

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 Andrew H. England

Licensed Embalmer No. 4745

P. O. Address He Sato, 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.