

No. 300
10. 48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Motor 33610
State File No.

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>531</u>		Registrar's No. <u>2374</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>University City</u>		c. LENGTH OF STAY (in this place) <u>5mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Hartson</u>		<u>1070</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1019 East Park</u>				d. STREET ADDRESS (If rural, give location) <u>RURAL</u>			
3. NAME OF DECEASED a. (First) <u>Sarah</u> * (Type or Print)			b. (Middle) <u>Isabelle</u>		c. (Last) <u>Crabtree</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 13, 1952</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 20, 1878</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Akers, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Riley</u>			13b. MOTHER'S MAIDEN NAME <u>Mattie Powell</u>		14. NAME OF HUSBAND OR WIFE <u>John Crabtree (dec'd)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Raymond Crabtree, 1019 E. Park.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Myocardial Infarction</u>		<u>1 1/2 hr</u>	
				DUE TO (c) <u>Ch. Endocarditis</u>		<u>years</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Ch. Myocarditis</u>					
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , <u>19</u> to <u>Sept 13, 1952</u> , that I last saw the deceased alive on <u>Sept 12, 1952</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>John Shamus M.D.</u> (Degree or title)				23b. ADDRESS <u>4500 Olive St. St. Louis Mo</u>		23c. DATE SIGNED <u>9/13/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9-13-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Riley</u>		24d. LOCATION (City, town, or county) (State) <u>Hartson, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>9-13-52</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Dombke MD</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington</u>		

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

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 _____

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.