

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 22 1953

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>14</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Arkansas</u> b. COUNTY <u>Pulaski</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville</u>		c. LENGTH OF STAY (In this place) <u>36 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Little Rock</u>		<u>80-30</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home #1</u>				d. STREET ADDRESS (If rural, give location) <u>3301 Fair Park Blvd.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah</u>		b. (Middle) <u>E.</u>		c. (Last) <u>Haley</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 14, 1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 20, 1881</u>		9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Willmathville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Newton Sammons</u>		13b. MOTHER'S MAIDEN NAME <u>Armilda March</u>		14. NAME OF HUSBAND OR WIFE <u>Geo. W. Haley</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>Geo. W. Haley, Little Rock, Ark.</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive vascular disease</u>					INTERVAL BETWEEN ONSET AND DEATH  <u>443X</u>	
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)		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)		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>Nov 8</u> , 19 <u>52</u> to <u>Jan 14</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>53</u> , and that death occurred at <u>3: P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>David W. Boon M.D.</u>				23b. ADDRESS <u>Kirksville, Mo.</u>		23c. DATE SIGNED <u>1-14-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1/15/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Little Rock, Ark.</u>		24d. LOCATION (City, town, or county) (State) <u>Little Rock, Ark.</u>		
DATE REC'D BY LOCAL REG. <u>1-14-53</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert 1-0</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kirksville, Mo.</u>			

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

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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

*Richard H. Randall*

Licensed Embalmer No. 4866

P. O. Address Fiskville, 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.