

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28456

FILED AUG 31 1953

BIRTH NO. _____ REG. DIST. NO. 143 PRIMARY REG. DIST. NO. 4232 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willow Springs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willow Springs	
c. LENGTH OF STAY (In this place) Yes.		d. STREET ADDRESS (If rural, give location) 500 Park St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home			

3. NAME OF DECEASED (Type or Print) a. (First) Sarah	b. (Middle) A.	c. (Last) SCARBROUGH	4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 3, 1875	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 6 Days 22	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Miller County, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Allen	13b. MOTHER'S MAIDEN NAME Nancy Jane Smith	14. NAME OF HUSBAND OR WIFE Albert J. Scarbrough
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. - -	17. INFORMANT'S SIGNATURE OR NAME ADDRESS A.J. Scarbrough, Willow Spgs., Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH One Week Hospital
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage Cerebral		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, Cerebral DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS 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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1/1, 1952 to 8/25, 1953, that I last saw the deceased alive on 8/25-53, 1953, and that death occurred at 9:42P m., from the causes and on the date stated above.

23a. SIGNATURE Dr. M.B. Perkins (Degree or title) MD	23b. ADDRESS Willow Springs, Mo.	23c. DATE SIGNED 8-26-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-27-53	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) Willow Springs, Mo.
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DATE REC'D BY LOCAL REG. 8/29/53	REGISTRAR'S SIGNATURE Middleton Ballard	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Burns Funeral Home, Willow Springs, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

460

0460

0

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334 X

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.

Fred W. Barnes

Student
Student Embalmer

Signed _____
Fred W. Barnes

Licensed Embalmer No. 4614

P. O. Address Willow Springs, 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.