

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007088

STATE FILE NUMBER

2 1090

FILED FEB 17 1959

Registration District No.

Primary Registration District No.

Registration No.

300
-57
D3
I

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Anna	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 316 So., St.	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
SARAH DEBOW FASIG			JANUARY 29, 1959			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1870	9. AGE (In years less birthday) 88	IF UNDER 1 YEAR Months Days	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 At Home	11. BIRTHPLACE (City and state or country) Anna, Illinois.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Thomas M. Perrine	13b. MOTHER'S MAIDEN NAME Mary Davie	14. NAME OF HUSBAND OR WIFE Arnaud
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No. Nil.	16. SOCIAL SECURITY NO. None	17. INFORMANT Gale J. Wilson, 4821 Fairview, Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 48 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROSIS	3 YEARS
	DUE TO (c) 331X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from JAN. 26, 1959 to JAN. 29, 1959 and last saw her alive on JAN. 29, 1959 Death occurred at 8:55 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. D. Vermillion, M.D.</i>	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/29/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-29-59	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Jonesboro, Illinois.
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24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. JAN 30 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Elton H. Remelius*

Licensed Embalmer No. *4293*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.