

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 20 1960

-60-025375

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1827 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saint Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saint Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay (25)</u>		Length of stay in lb <u>2 Years</u>	c. CITY OR TOWN <u>Lemay (25)</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>719 Horn Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>719 Horn Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH A. BURROUGHS</u>			4. DATE OF DEATH Month Day Year <u>June 11, 1960</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/75</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Mountain View, Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Bud Holt</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Wallace</u>	14. NAME OF HUSBAND OR WIFE <u>Albert (Deceased)</u>
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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 Address <u>Mo. Jack Gowers 719 Horn Ave. Lemay (25)</u>
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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) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>a three sec. crisis</u> <u>years</u>	
	DUE TO (c) <u>Malignant Hypertension</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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

21. I attended the deceased from 10-3-58 to June 11, 1960 last saw her live on June 10, 1960
Death occurred at 8:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John C. Crawford D.D.</u>		22b. ADDRESS <u>9617 S. Broadway</u>	22c. DATE SIGNED <u>6-13-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 14, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Case Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mountain View, Arkansas</u>
24. FUNERAL DIRECTOR ADDRESS <u>Fondler Und. Co. 7420 Michigan Ave. (11)</u>	25. DATE RECD. BY LOCAL REG. <u>6-13-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Crawford</u>	

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

Dr. John B. Crawford
9614 So. Babadway
Inw. 2-3067
Hours 9:30 to 12 Mon. A.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Me

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.