

7. S. No. 2  
DOM-5-43  
Rev. 5-17-39  
I X36671

6833

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED FEB 24 1947  
Registration District No. 318

Primary Registration District No. 100

Registrar's No. 1642

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

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Pulaski 999

(c) City or town Mounds 11  
(If outside city or town limits, write "RURAL")

(d) Street No. NR-0  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SADIE E. QUARLES

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife G. M. Quarles

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased November 19 1894  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	2	17	hr. min.

9. Birthplace Mounds Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business Own Home

MOTHER FATHER { 12. Name T. A. Thomasson

13. Birthplace Jonesboro Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Allie Koonce

15. Birthplace Villa Ridge Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant G. M. Quarles

(b) Address Mounds, Ill.

17. (a) Burial (b) Date thereof 2-19-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mounds, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) FEB 17 1947 (b) J. F. Bredeck  
(Date received) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16  
year 1947 hour 4 minute 50 A.M.

21. I hereby certify that I attended the deceased from Jan 29, 1947, to Feb 16, 1947.  
that I last saw her alive on Feb 16, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor, malignant (Spongiosarcoma, multi-focal) (left cerebral hemisphere)

Due to \_\_\_\_\_

Due to JH

Other conditions Bronchopneumonia  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy As above

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature J. F. Bredeck (M. D. or other) \_\_\_\_\_

Address Barnes Hospital Date signed \_\_\_\_\_

---

---

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *J. W. Wilkins*.....  
Licensed Embalmer No..... *3575*.....  
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.**