

FILED MAR 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5897**

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 61

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u>		b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural St. Francois</u>		c. LENGTH OF STAY (in this place) <u>2Y. 7M. 17D</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Neelyville,</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR Missouri State Hospital No. 4 INSTITUTION.				d. STREET ADDRESS (If rural, give location) <u>Unknown</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>BESSIE</u>			b. (Middle)			c. (Last) <u>SANSOUCI</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>February 120, 1949</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>October 11, 1887</u>		9. AGE (In years last birthday) <u>61</u>		if UNDER 1 YEAR Months <u>4</u>	if UNDER 24 HRS. Days <u>9</u>	if UNDER 1 MIN. Hours <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Clay County, Arkansas / (?)</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>W. T. Caldwell</u>		13b. MOTHER'S MAIDEN NAME <u>Naomi Williams</u>		14. NAME OF HUSBAND OR WIFE <u>August Sansouci</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>Records, State Hospital No. 4, Farmington, Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Thrombosis</u>						<u>1 year.</u>	
		ANTECEDENT CAUSES							
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychosis with cerebral arteriosclerosis</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 December 1, 1948, to February 20, 1949, that I last saw the deceased alive on February 19, 1949, and that death occurred at 5:00 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. A. Brennan M.D.</u>		23b. ADDRESS <u>State Hosp. #4, Farmington, Mo.</u>		23c. DATE SIGNED <u>2/21/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 22, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Neelyville Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Neelyville, Missouri</u>	

DATE REC'D BY LOCAL REG. <u>Feb. 21, 1949</u>		REGISTRAR'S SIGNATURE <u>Ether R. Rudolph</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gish Funeral Home, Naylor, Missouri</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

948

RECEIVED

Health Officer No: 4  
Social Security Number 349-304  
Date Miled 3-1-49

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 Bert J. Miller

Licensed Embalmer No. 3752

P. O. Address Farmington 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.