

No. 308
10.4

XC 2058281

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29152**
Registrar's No. **2888**

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH a. COUNTY ST. LOUIS COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE ILLINOIS b. COUNTY MORGAN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFF. BRKS. MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MURRAYVILLE	
c. LENGTH OF STAY (In this place) 4 Days		8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSP.		d. STREET ADDRESS RR #1 (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) CHARLES	b. (Middle) OSCAR	c. (Last) SAWYER	8/11/51		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 8/10/88	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas City, Mo.	
				12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME William J. Sawyer	13b. MOTHER'S MAIDEN NAME Cornelia Scott	14. NAME OF HUSBAND OR WIFE NONE
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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) Yes World I	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME V. A. HOSPITAL RECORDS	ADDRESS JEFF BKRS 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL VASCULAR ACCIDENT		
	ANTECEDENT CAUSES DUE TO (b) GENERALIZED ARTERIOSCLEROSIS 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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE	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) V.A.	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 8/7, 1951, to 8/11, 1951, and that death occurred at 6:15 P. M., from the causes and on the date stated above.

23a. SIGNATURE George A. Make (Degree or title) M.D.	23b. ADDRESS V. A. HOSP. JEFF. BRKS. MO.	23c. DATE SIGNED 8-12-51
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 8-13-51	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Roodhouse, Ill.
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DATE REC'D BY LOCAL REG. 8-13-51	REGISTRAR'S SIGNATURE Herbert P. Jorjick	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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(Licensed Embalmer, Statement on Reverse Side)

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

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 ME

Student Embalmer No. _____

working under my personal supervision. .

Student
Student Embalmer

Signed

G. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis 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.