

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2606

State File No. ....

0347

Registrar's No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b> c. LENGTH OF STAY (in this place) <b>2 DAYS</b> d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b> (If not in hospital or institution, give street address or location)		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Saline</b> c. CITY OR TOWN <b>Carrier Mills</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <b>312 C 8</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Syble</b> b. (Middle) <b>Belle</b> c. (Last) <b>Bozarth</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>January 12, 1954</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Feb. 4, 1904</b>
<b>9. AGE</b> (In years last birthday) <b>49.</b> If UNDER 1 YEAR Months _____ Days _____ If UNDER 24 HRS. Hours _____ Min. _____		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Saline County, Illinois,</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home.</b>	
<b>13a. FATHER'S NAME</b> <b>Jasper Strickland</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Ellen Reynolds</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ed. Bozarth.</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <b>None.</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mildred Strickland,</b> ADDRESS <b>Stone Fort Ill.</b>	
<b>18. CAUSE OF DEATH</b> 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.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION—DIRECTLY LEADING TO DEATH* (a)</b> <b>Chronic adrenal insufficiency</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Addison's disease</b> DUE TO (c) _____ <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>Pulmonary edema</b>	
<b>19a. DATE OF OPERATION</b> _____		<b>19b. MAJOR FINDINGS OF OPERATION</b> _____	
<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>21. INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 months</b>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____		<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.) _____	
<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <b>274X</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>1/10</u> , 19 <u>54</u> , to <u>1/12</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>1/12</u> , 19 <u>54</u> , and that death occurred at <u>3:47 a.m.</u> , from the causes and on the date stated above.			
<b>23a. SIGNATURE</b> <i>ET R Bradley</i>		<b>23b. ADDRESS</b> <b>M.D. BARNES HOSPITAL</b>	
<b>23c. DATE SIGNED</b> <b>1/12/54</b>		<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	
<b>24b. DATE</b> <b>1-12-54</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Garris Cemetery</b>	
<b>24d. LOCATION</b> (City, town, or county) (State) <b>Stone Fort, Illinois,</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington.</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>JAN 18 1954</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Carl Smith</i>	

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..... *J. Wm. Dumbley*

Licensed Embalmer No..... *36*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.