

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3590

State File No. ....

FILED JAN 26 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warson Woods</u>		c. CITY OR TOWN <u>Warson Woods</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>unk</u>		e. STREET ADDRESS (If rural, give location) <u>1509 Andrews drive</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>1509 Andrews Drive</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah</u> b. (Middle) <u>Dixon</u> c. (Last) <u>Osburn</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1-8-54</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>2-24-1876</u>		9. AGE (In years last birthday) <u>77</u>		# UNDER 1 YEAR: Months _____ Days _____ # UNDER 1 MTH: Hours _____ Mins _____	
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 <u>at home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Piggott, Ark.</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>F. L. McLeokey</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Knox</u>		14. NAME OF HUSBAND OR WIFE <u>Robert L. Osburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert Osburn, 1509 Andrews dr.</u>	

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 <u>1 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Disruptive Heart Disease with Acute Pulmonary Edema</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <u>5272</u>		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 Jan 8, 1954, to Jan 8, 1954, that I last saw the deceased alive on Jan 7, 1954, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Louis J. Carter M.D.</u>		23b. ADDRESS <u>3720 Washington St. L. 8</u>		23c. DATE SIGNED <u>1-9-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>1-9-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Gideon, Mo.</u>	
24d. LOCATION (City, town, or county) (State)					

DATE REC'D BY LOCAL REG. <u>1/13/54</u>		REGISTRAR'S SIGNATURE <u>Heather B. Aronke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Russell, Gideon, Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

4000

FEB 23 1955

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... *Albert Mayfield* .....  
Licensed Embalmer No. *307* .....  
P. O. Address *St. Louis* .....

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.