

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9871**  
**2468**  
Registrar's No.

BIRTH NO. FILED **MAR 19 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>2139</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place) <b>11 yrs</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>			
3. NAME OF DECEASED (Type or Print) <b>SARAH</b>		4. DATE OF DEATH <b>March 16, 1954</b>	
a. (First)		b. (Middle)	
c. (Last)		e. STREET ADDRESS (If rural, give location) <b>13 5100 Arsenal St.</b>	
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5 - 12 - 1882</b>
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Ohio /</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>John Simmons</b>	
13b. MOTHER'S MAIDEN NAME <b>unknown Rine</b>		14. NAME OF HUSBAND OR WIFE <b>Robert Barclay</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Charlotte Wagner</b>		ADDRESS <b>5141 Terry</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lukemia, chronic, lymphatic type</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
DUO TO (b) <b>Arteriosclerotic heart disease</b>			<b>2 yrs.x</b>
DUO TO (c)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>2040</b>	
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 <b>Jan. 1, 1953</b> , to <b>Mar. 16, 1954</b> , that I last saw the deceased alive on <b>Mar. 16, 1954</b> and that death occurred at <b>9:45a m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <i>Walter R. Gale, M.D.</i>		23b. ADDRESS <b>5100 Arsenal St.</b>	23c. DATE SIGNED <b>3/16/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3/18/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>MAR 17 1954</b> <i>J. Earl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Drehmann-Harral 1905 Union Blvd.</b>		

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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 *Warren A. Carver*.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.