

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023158

FILED JUL 3 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

STATE, FILE NO. 2-5475  
Registrars No. \_\_\_\_\_

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W.

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Webster Groves 19</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda Gen Hosp</b>		Length of stay in 1b <b>58 yrs</b>	
d. STREET ADDRESS <b>Bethesda Dilworth Hm.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH ELIZABETH WILSON Mc COY</b>			4. DATE OF DEATH Month Day Year <b>June 7, 1959</b>
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1868</b>
9. AGE (in years last birthday) <b>90</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	11. BIRTHPLACE (City and state or country) <b>Jackson Co, Missouri</b>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Rufus Wilson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ann Moore</b>	14. NAME OF HUSBAND OR WIFE <b>Wm. C. McCoy</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mr Fred W. McCoy 2237 St. Clair Ave</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic vascular disease</b>			<b>chr.</b>
DUE TO (c) <b>332xH</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Upper abdominal Mass Ca of the Pancreas?</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Feb 15 1959</b> to <b>June 7 1959</b> and last saw her alive on <b>June 6 1959</b> . Death occurred at <b>6:30 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>D. Deabough M.D.</b>		22b. ADDRESS <b>Webster Groves Mo</b>	
		22c. DATE SIGNED <b>6/8/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6/9/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons 6175 Delmar Blv</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 8 '59</b>	
26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>			

Dr. O. D. Seabaugh  
105 W. Lockwood Ave.  
WO 1 5002

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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 *jos. E. McCallan* .....

Licensed Embalmer No. *2460*

P.O. Address *677 1/2 Hillme*

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.