

318 Primary Registration District No. 1003 Registrar's No. 4624

STATE FILE NUMBER

Registration District No. **FILED MAY 19 1961**

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2911 Lucas	
3. NAME OF DECEASED (Type or print) First Sarah Middle Saunders Last		4. DATE OF DEATH Month 5 Day 12 Year 61	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/26/1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) 82
11. BIRTHPLACE (City and state or country) Mississippi		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Jefferson Davis		13b. MOTHER'S MAIDEN NAME Nancy Whitehead	
14. NAME OF HUSBAND OR WIFE None		17. INFORMANT Mrs. Pearl Williams Address 116 W. Scott St.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Cerebral Thrombosis DUE TO (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH Undet. Undet. Undet.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 a.m. p.m. Month, Day, Year		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 5-6-61 to 5-12-61 and last saw her xxx alive on 5-12-61 Death occurred at 11:35 a. m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS 2601 N. Whittier St.	
22c. DATE SIGNED 5-15-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/17/61	23c. NAME OF CEMETERY OR CREMATORY Century Burial Association	23d. LOCATION (City, town, or county) (State) Winona, Mississippi
24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS 1221 North Grand		25. DATE RECD. BY LOCAL REG. MAY 16 1961	26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M. D.

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 Milva Blackman

Licensed Embalmer No. 3963

P. O. Address 1221 N. Green

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.