

NOV 13 1939
Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH: 1008
(a) County 1
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: BARNES HOSPITAL
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days 4.50

2. USUAL RESIDENCE OF DECEASED:
(a) State Kentucky (b) County 2
(c) City or town Louisville
(d) Street No. 611 E. Broadway
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Henry Charles Harthill
(b) If veteran, name war no (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 11
year 1939 hour 7 minute 15 P. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
7. Birth date of deceased 11 29 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 2, 1939 to Oct 11, 1939
that I last saw him alive on Oct 11, 1939
and that death occurred on the date and hour stated above.

8. AGE: Years 56 Months 10 Days 12 If less than one day hr. _____ min. _____

Immediate cause of death Carcinoma of lung, etc. Lye
bronchogenic

9. Birthplace Louisville Ky
(City, town, or county) (State or foreign country)

Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Veterinarian
11. Industry or business own business
12. Name Alexander Harthill
13. Birthplace Scotland
(City, town, or county) (State or foreign country)

Major findings: Carcinoma of right lung
Of operations _____
Of autopsy _____

14. Maiden name Bertha Cooney
15. Birthplace New York
(City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs. Ida Harthill
(b) Address 611 E. Broadway Louisville, Ky.
17. (a) Removal (b) Date thereof 10/12/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Louisville, Ky.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington
19. (a) OCT 12 1939 (b) _____
(Date received local registrar) (Signature of Registrar)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature O. S. Scher (M. D. or other) _____
Address BARNES HOSPITAL Date signed _____

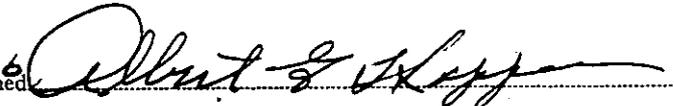
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X1931 USE PREVIOUS EDITIONS OF THIS FORM—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed 

Licensed Embalmer No. 2971

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 this body is not embalmed, above space should be left blank.