

**FILED SEP 8 1941**

Registration District No. **784** Primary Registration District No. **200**

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

**1. PLACE OF DEATH:**  
 (a) County ST. LOUIS  
 (b) City or town KOCH  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution ROBERT KOCH HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 314 days  
 (Specify whether years, months or days)  
 In this community \_\_\_\_\_

**3. (a) PRINT FULL NAME** JUANITA HARSTON  
 3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex FEMALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife MILTRAC HARSTON 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 7 - 4 - 14  
 (Month) (Day) (Year)

**8. AGE:** Years 27 Months 1 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace ST. LOUIS OMO.  
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

**MOTHER FATHER**  
 12. Name MARY MONTGOMERY  
 13. Birthplace KENTUCKY  
 (City, town, or county) (State or foreign country)  
 14. Maiden name MAMIE BLUE  
 15. Birthplace ? ?  
 (City, town, or county) (State or foreign country)

16. (a) Informant PATIENT

(b) Address 2329 Scott 1941

17. (a) Burial (b) Date thereof 9 19 41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director J. Harrison

(b) Address 2906 Lafayette

19. (a) AUG 19 1941 (b) C. M. Lawrence, MD  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MISSOURI (b) County - 1000  
 (c) City or town ST. LOUIS 17  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2329 Scott Ave. 9  
 (If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 8 day 16  
 year 1941 hour 5 minute 10 A.M.  
 21. I hereby certify that I attended the deceased from 2 - 1940 to 8 - 16 - 1941  
 that I last saw Y alive on 8 - 15 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis  
 Due to \_\_\_\_\_  
 Due to 13/11

Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings: Rt. Thoracoplasty  
 Of operations Pulmonary Tuberculosis  
 Of autopsy Pulmonary Tuberculosis

Duration 7 yrs?  
**PHYSICIAN**  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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 Samuel J. Greenhill (M. D. or other) MD  
 Address Koch, MO. Date signed 8/16/41

Dr. Samuel S. Bonnell  
Jack Hoop

**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. ~~760~~

working under my personal supervision.

Signed.....

*Jack Harrison*

Licensed Embalmer No. 760

P. O. Address.....

*2906 Lawton*

**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, fact should be so stated above.**