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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 8044

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County St. Louis, Missouri.  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 days  
(Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County JCO  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5246 Maple  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Ellen Harrison

MEDICAL CERTIFICATION

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Sept. day 9th  
year 1943 hour 7:05 minute \_\_\_\_\_ P.M.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced, widow  
6. (b) Name of husband or wife James J. Harrison 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 25th, 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from August 19th 1943, to Sept. 8th 1943; that I last saw her alive on Sept. 8th 1943; and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 8 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral Nemon hage Bronchis pneumonia Duration \_\_\_\_\_

9. Birthplace Ireland (City, town, or county) (State or foreign country) 4

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 80

10. Usual occupation Housework

Major findings: Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Of autopsy \_\_\_\_\_

12. Name John Murphy

13. Birthplace Ireland (City, town, or county) (State or foreign country) 4

14. Maiden name Margaret Carroll

15. Birthplace Ireland (City, town, or county) (State or foreign country) 4

16. (a) Informant Mrs Margaret A. Sullivan

(b) Address 5246 Maple

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/43 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Sullivan Bros

(b) Address 2349 N. Euclid Av.  
19. (a) SEP 9 1943 (Date received local registrar) (b) [Signature] (Registrar's signature)

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)  
Means of injury 0

23. Signature [Signature] (M. D. or other)

Address 1515 Lafayette Date signed 9/9/43

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Albert Mayfield* .....

Licensed Embalmer No..... *3079* .....

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, fact should be so stated above.**