

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 211

1. PLACE OF DEATH:

(a) County R. H. St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-1-2 yrs.
(Specify whether years, months or days)

In this community 2-1-2 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 710

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 9117 Clayton Road
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME ANNA HARKINS

3. (b) If veteran, name war _____ 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Don't know
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15th
year 1945 hour 2 minute 58 P. M.

21. I hereby certify that I attended the deceased from Sept 19
1931 to March 15, 1945
that I last saw her alive on March 14, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
about 67 hr. min.

Immediate cause of death Arteriosclerotic Cardio-vascular Disease

Due to _____

Due to _____

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

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Harmonia

11. Industry or business _____

MOTHER FATHER { 12. Name Edna Mae Har Kins

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

14. Maiden name Cath. Gellan

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

16. (a) Informant Mrs. John J. Griffin

(b) Address 9117 Clayton Rod.

17. (a) Burial (b) Date hereof 3 19 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cathary

18. (a) Signature of funeral director Thos. J. Finnan

(b) Address 1519 So. Grand

19. (a) MAR 19 1945 (b) E. B. McConary, M.D.
(Date received local registrar) (Physician's signature)

Major findings: Of operations _____

Of autopsy 928

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature G. O. Brown (M. D. or other) M.D.

Address 1325 S. Grand Blvd Date signed 3/16/45

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

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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 John Ketter

Licensed Embalmer No. 3882

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.