

FILED JUN 28 1948

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Malcolm Bliss Hospital **0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Catherine F. Harkins  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow **2**  
6. (b) Name of husband or wife Frank X Harkins 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 24 1879  
(Month) (Day) (Year)

8. AGE: Years 69 Months 0 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Litchfield Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Pat Danaher  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Unknown  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Daniel Harkins  
(b) Address 4442 a Lexington Ave

17. (a) Burial (b) Date thereof 6/7/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll  
(b) Address 4600 Natural Bridge Ave

19. (a) JUN 4 1948 (b) J. F. Bruck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis **17**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4442 a Lexington **7**  
(If rural, give location) **0**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3  
year 1948 hour 7 minute 15 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to Cerebral Gyraly  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 00

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

Duration \_\_\_\_\_  
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)  
Means of injury \_\_\_\_\_  
23. Signature John E. Gaylor (M.D. or other) **3**  
Address \_\_\_\_\_ Date signed 6/7/48

WRITE PLAINLY - USE ON REVERSE

**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.....

*Allen Davis*  
.....  
Licensed Embalmer No. *4053.*  
P. O. Address..... *Davis Mo.*

**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.**