

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21119

State File No. 5885

FILED JUL 15 1949

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY <b>MO</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (In this place) <b>0</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		<b>17</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Honer G. Phillips</b>				d. STREET ADDRESS (If rural, give location) <b>24 2408 Biddle</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Henry</b>			b. (Middle) <b>Hart</b>		c. (Last) <b>Hart</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 3 1949</b>
5. SEX <b>m</b>	6. COLOR OR RACE <b>col</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>JAN 1 - 1883</b>	9. AGE (In years last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Friendship Tenn</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Eugene Hart</b>			13b. MOTHER'S MAIDEN NAME <b>Paralee Seales</b>		14. NAME OF HUSBAND OR WIFE <b>Marie Hart</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Marie Hart</b> ADDRESS <b>2225 Eugenia</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.							
MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b>				INTERVAL BETWEEN ONSET AND DEATH _____			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Pulmonary</b>							
DUE TO (c) <b>Tuberculosis</b>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>10 MO MO</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>002X</b>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>9:58 P.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Joseph Thomas Hart</b> (Degree or title) _____			23b. ADDRESS <b>1200 Clark</b>			23c. DATE SIGNED <b>7/5/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>July 8/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>	
DATE REC'D BY LOCAL REG. <b>JUL 6 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Laster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. A. Green 4214 Delmar</b>			

WRITE PLAINLY—USING UNFAADING BLACK INK—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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Signed

*F. A. Sheen*

Licensed Embalmer No.

*2963*

P. O. Address

*4714 Delmar*

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.