

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19464

FILED FEB 23 1951

BIRTH NO. 52794-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 19464

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2199			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis - Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis - Mo.		d. STREET ADDRESS (If rural, give location) 4052 Hillmar	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens Hospital				d. STREET ADDRESS (If rural, give location) 4052 Hillmar			
3. NAME OF DECEASED (Type or Print) a. (First) Jolyn		b. (Middle) <del>Walter</del>		c. (Last) Harris		4. DATE OF DEATH (Month) (Day) (Year) Feb 11 - 1951	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify)		8. DATE OF BIRTH Aug 8 - 1950	
9. AGE (In years last birthday) 6 6		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis - Mo. 0	
12. CITIZEN OF WHAT COUNTRY? Amer							
13a. FATHER'S NAME Walter Harris			13b. MOTHER'S MAIDEN NAME Lylvia Knight			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS			
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) Osteogenesis imperfecta							
ANTECEDENT CAUSES							
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
DUE TO (b) _____							
DUE TO (c) _____							
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 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)			
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? 750, 3			
22. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred _____, 19____, from the causes and on the date stated above. 8:15 P.							
23a. SIGNATURE Wm. Klingberg MD 0				23b. ADDRESS Barns Hospital		23c. DATE SIGNED 2-12-51	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 2-14-51		24c. NAME OF CEMETERY OR CREMATORY Washington Bx		24d. LOCATION (City, town, or county) (State) St. Louis Mo's	
DATE REC'D BY LOCAL FEB 13 1951		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Athens Prod. 3644 Finney			

(Licensed Embalmer's Statement on Reverse Side)

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

*Finley*

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No.....

Signed *Louis V. Watkins*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2842*

P. O. Address *3644 Finney*

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.