

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10169

State File No. ....

FILED MAR 19 1951

BIRTH NO. ....		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>2035</u>			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>ST. LOUIS,</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS,</u>		2119			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4577 a KENNERLY AVE</u>				d. STREET ADDRESS (If rural, give location) <u>11 4577 a KENNERLY AVE</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u>			b. (Middle)		c. (Last) <u>HARLAND</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 1, 1951</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u> (Specify)		8. DATE OF BIRTH <u>2/27/1885</u>		9. AGE (In years last birthday) <u>66</u> IF OVER 1 YEAR Months Days IF OVER 6 HRS. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT WATCHMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ROBERT HARLAND</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>PEARL HARLAND</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>489-09 7234</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>PEARL HARLAND 4577 a KENNERLY AVE</u>				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Artery Disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>  <u>3 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? <u>4201</u>					
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>49</u> , to <u>3-1</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3-1</u> , 19 <u>51</u> , and that death occurred at <u>8<sup>00</sup></u> a. m., from the causes and on the date stated above.									
23a. SIGNATURE <u>Joseph B. Guccione M.D.</u> (Degree or title)				23b. ADDRESS <u>280 N. Taylor St.</u>		23c. DATE SIGNED <u>3-2-51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3/3/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO.</u>			
DATE REC'D BY LOCAL HEALTH DEPT. <u>MAR 2 1951</u>		REGISTRAR'S SIGNATURE <u>J. P. Kester</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STROOT - CARROLL 1600 NATURAL BRIDGE</u>				

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

10010

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.....

*J. W. B. Embalmer*

Signed.....  
Student Embalmer

Licensed Embalmer No. *3653*

P. O. Address *St Louis 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.