

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10047

State File No.

2149

FILED MAR 24 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Mo**
b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **ST. LOUIS**

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **ST. LOUIS 2139**

d. FULL NAME OF HOSPITAL OR INSTITUTION **3205 Regal Place**

d. STREET ADDRESS (If rural, give location) **13 3205 Regal Place**

3. NAME OF DECEASED
a. (First) **IRENE** b. (Middle) **T** c. (Last) **HARRIS**

4. DATE OF DEATH (Month) (Day) (Year) **MARCH 5-52**

5. SEX **Fe**

6. COLOR OR RACE **W**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **m.**

8. DATE OF BIRTH **JAN-27-1909**

9. AGE (In years last birthday) Months Days Hours Min. **43**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSEWIFE**

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) **ST. LOUIS Mo 0**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **UNKNOWN NORTON**

13b. MOTHER'S MAIDEN NAME **IRENE UNKNOWN**

14. NAME OF HUSBAND OR WIFE **John D. HARRIS**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No**

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **John D. Harris 3205 Regal Place**

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Acute Cholecystitis**
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) **Chronic Myocarditis**
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 _____

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **4222**

22. I hereby certify that I attended the deceased from **2/24, 1952 to 3/5, 1952**, that I last saw the deceased alive on **3/4, 1952**, and that death occurred at **8 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Chas. Hauer MD**

23b. ADDRESS **3012 Lafayette**

23c. DATE SIGNED **3/6/52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **REMOVAL**

24b. DATE **MARCH 8-52**

24c. NAME OF CEMETERY OR CREMATORY **MEMORIAL PARK**

24d. LOCATION (City, town, or county) (State) **St. Louis, Mo**

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE **MAR 6 1952**

REGISTRAR'S SIGNATURE **Carl Smith**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **E. J. Schmur 3125 Lafayette**

WRITE PLAINLY—USING UNFADING 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.

Student
Student Embalmer

Signed Joseph B. Vollemer

Licensed Embalmer No. 4014

P. O. Address 325 Lafayette Ave

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.