

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36441**  
Registrar's No. **9315**

FILED OCT 21 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Licking</b> <b>1070</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Nancy</b> b. (Middle) <b>Elizabeth</b> c. (Last) <b>Harland</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 7, 1952</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 8, 1896</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Texas Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>John Isaac</b>	13b. MOTHER'S MAIDEN NAME <b>Rose Kimery</b>	14. NAME OF HUSBAND OR WIFE <b>William E.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>William E. Harland, Licking, Mo.</b>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>BRAIN TUMOR, ADJUVANT RT-PARIENTAL</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b>
	ANTECEDENT CAUSES Morbid 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 <b>Sept 6, 1952</b>	19b. MAJOR FINDINGS OF OPERATION <b>BRAIN TUMOR, GLIOBLASTOMA, RT-Pariental</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>NO</b>	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>193X</b>

22. I hereby certify that I attended the deceased from **Oct 1, 1952**, to **Oct 6, 1952**, that I last saw the deceased alive on **Sept 4, 1952**, and that death occurred at **4:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>George H. Howkins, M.D.</b>	23b. ADDRESS <b>607 N. Grand St. Louis</b>	23c. DATE SIGNED <b>Oct 7, 1952</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10-7-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City</b>	24d. LOCATION (City, town, or county) (State) <b>Licking, Mo.</b>

DATE REC'D BY LOCAL REG. <b>OCT 8 1952</b>	REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>
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**MDS** (Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

*John S. Henne*  
Licensed Embalmer No. *4697*  
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.