

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10089**
2392

FILED MAR 19 1954

318

1003

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No.			
1. PLACE OF DEATH a. COUNTY None				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY None 2067					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 0			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 6 5157 Lexington Avenue					
3. NAME OF DECEASED (Type or Print) a. (First) Annie			b. (Middle)		c. (Last) HARDING		4. DATE OF DEATH (Month) (Day) (Year) March 12, 1954		
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH about		9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Unavailable			13b. MOTHER'S MAIDEN NAME Unavailable		14. NAME OF HUSBAND OR WIFE - - -				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - -		17. INFORMANT'S SIGNATURE OR NAME ADDRESS James R. Harding, 5157 Lexington Ave.					
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.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure ANTECEDENT CAUSES Hypertension 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.					INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 yr		
19a. DATE OF OPERATION 0		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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4341					
22. I hereby certify that I attended the deceased from Aug 1, 1954 , to Mar 12, 1954 , that I last saw the deceased alive on Mar 12, 1954 , and that death occurred at 11:54 a.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Walter G. George MD				23b. ADDRESS 5387 Market Street No		23c. DATE SIGNED 3/15/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3/16/54	24c. NAME OF CEMETERY OR CREMATORY Washington Park, Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.				
DATE REC'D BY LOCAL REG. MAR 15 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Atkins Bros. Und. Co., 3644 Finney Avenue					

(Licensed Embalmer's Statement on Reverse Side)

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

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VS APR 28 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John F. Cunningham*.....
Licensed Embalmer No. 4476..

P. O. Address 4700. Hammett.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.