

FILED AUG 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24632**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6730**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION 5103 Terry		e. STREET ADDRESS (If rural, give location) 6 5103 Terry	

20690

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) B. c. (Last) Harrison		4. DATE OF DEATH (Month) 7 (Day) 18 (Year) 54	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5-9-1866
9. AGE (in years last birthday) 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	11. BIRTHPLACE (City and State or Foreign Country) Cotton Valley, Louisiana
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dave Bell	

13b. MOTHER'S MAIDEN NAME Chirtey ?		14. NAME OF HUSBAND OR WIFE Henry Harrison	
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. None	
17. INFORMANT'S SIGNATURE OR NAME Daisy Hayes		ADDRESS 5103 Terry	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach		
	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	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) 151X
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?

22. I hereby certify that I attended the deceased from **March 10, 1954** to **July 18, 1954**, that I last saw the deceased alive on **July 17, 1954**, and that death occurred at **7:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Chas. P. Forde	(Degree or title) M.D.	23b. ADDRESS 2746 Franklin Ave	23c. DATE SIGNED 7-19-54
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 7-21-54	24c. NAME OF CEMETERY OR CREMATORY HOPE	24d. LOCATION (City, town, or county) (State) ARK.

DATE REC'D BY LOCAL REG. JUL 21 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home, Inc.	ADDRESS 2820 Stoddard St.
--	---	---	-------------------------------------

S.P. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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.....
Signature of Student Embalmer

Signed... *H. E. Calk*

Licensed Embalmer No. *419*

P. O. Address... *101...*

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**