

FILED JUN 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20084
Registrar's No. 5008

BIRTH NO. _____ 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		STREET ADDRESS (If rural, give location) 21 1915 O'Fallon	

3. NAME OF DECEASED (Type or Print) Doctor	a. (First)	b. (Middle)	c. (Last) Harris	4. DATE OF DEATH (Month) (Day) (Year) June 8, 1955
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5. SEX M	6. COLOR OR RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	8. DATE OF BIRTH 12-25-1896	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months 5 Days 14	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY HOOD CARRIER		11. BIRTHPLACE (City and State or Foreign Country) ARK.		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME JOHN HARRIS	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE UNKNOWN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Mary Mitchell	ADDRESS 1812 Papan
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate with Metastases		DUPLICATE		Undt.
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Metastases		
		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"/>
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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)
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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? 177X
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22. I hereby certify that I attended the deceased from **4-21**, 19**55**, to **6-8**, 19**55**, that I last saw the deceased alive on **6-8**, 19**55**, and that death occurred at **4:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Mable Herrigford (Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 6-8-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) 6-13-55	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY OAK DALE CEM.	24d. LOCATION (City, town, or county) (State) Lemay St. LO MO
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DATE REC'D BY LOCAL REG. JUN 9 1955	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Walter Funeral Home	ADDRESS 2707 Stoddard St.
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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.....
Signature of Student Embalmer

Signed *W Claude Gonder*

Licensed Embalmer No. *348*

P. O. Address *4575 Al*

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.