

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21899

State File No. \_\_\_\_\_  
Registrar's No. **5555**

FILED JUN 29 1956

318

1003

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

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 OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips		d. STREET ADDRESS 932 Hodiamont Ave.		2059	
3. NAME OF DECEASED (Type or Print) Leaveritte Har Harrison			4. DATE OF DEATH (Month) (Day) (Year) 6 - 9 - 56		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 9-2-96		9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR (Months) (Days) Hours (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (City and State or Foreign Country) / Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE Willie Ann Hubbard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.I		16. SOCIAL SECURITY NO. 486-28-1360	
17. INFORMANT'S SIGNATURE OR NAME Willie Ann Hubbard		ADDRESS 932 Hodiamont		MEDICAL CERTIFICATION	
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) Carcinoma of Lungs with Metastasis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (a) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHOLE 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:30 A.M., from the causes and on the date stated above.					
23a. SIGNATURE <i>Edward E. Taylor</i>		23b. ADDRESS 1390 Clark Ave		23c. DATE SIGNED 6/10/56	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-14-56		24c. NAME OF CEMETERY OR CREMATORY National Cemetery	
24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE <i>Dement &amp; Son</i>		ADDRESS 2629-31 Cole St.	

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.....

.....  
working under my personal supervision.

Student Embalmer No. ....

Student .....  
Student Embalmer

Signed

*W. B. Claude Gordon*

Licensed Embalmer No.

*3489*

P. O. Address

*4575 Alden*

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.