Health, Welfare Public Service

300 0
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 28 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

39453

STATE FILE NUMBER

80819-56 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9951

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, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Homer G. Phillips — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1632 Cole — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Lutrilla	Middle:	Last: Harris	4. DATE OF DEATH	Month 10 Day 29 Year 56
5. SEX: Female	6. COLOR OR RACE: Negro	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 9-9-56	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months 1 Days 20 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE	10b. KIND OF BUSINESS OR INDUSTRY: NONE	11. BIRTHPLACE (City and state or country): St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Robert Harris		14. MOTHER'S MAIDEN NAME: Lutrilla Redmond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: NONE	17. INFORMANT: LUTRILLA HARRIS	Address: 1632 COLE		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Meningomyelocele — INTERVAL BETWEEN ONSET AND DEATH: undet

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 751X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arnold Chiari Malformation - Hydrocephalus - Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 9-9-56, to 10-29-56 and last saw her/him alive on 10-29-56

Death occurred at 7:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Helen Nash, M. D.	22b. ADDRESS: 2601 Whittier Street	22c. DATE SIGNED: 10-31-56
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 11-1-56	23c. NAME OF CEMETERY OR CREMATORY: GREENWOOD
23d. LOCATION (City, town, or county) (State): 6571 St. LOUIS AVE. MO		
24. FUNERAL DIRECTOR: E. J. Golden — ADDRESS: 3404 Delmar	25. DATE RECD. BY LOCAL REG.: NOV 1 1956	26. REGISTRAR'S SIGNATURE: Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 4

P. O. Address 3404

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.