FILED JAN 25 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2779

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 85

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 11 FIRMIN DESLOGE Hospital — Length of stay in 1b 2137
d. STREET ADDRESS (If outside, give location) 3276 MACKLIND — Reside on Farm Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ROBERT Middle FRANCIS Last HARRIS
4. DATE OF DEATH Month JAN. Day 2 Year 1957
5. SEX Male
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH AUG. 28 1923
9. AGE (In years last birthday) 33 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CREDIT OFFICE
10b. KIND OF BUSINESS OR INDUSTRY INT. SHOE CO
11. BIRTHPLACE (City and state or country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U-S-A
13. FATHER'S NAME FRANK HARRIS
14. MOTHER'S MAIDEN NAME EDNA KIEFER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WAR II
16. SOCIAL SECURITY NO. 346-14-4776
17. INFORMANT EDNA HARRIS Address 3276 MACKLIND

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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 10 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
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 Jan 2, 1957, to Jan 2, 1957 and last saw her/him alive on Jan 2, 1957
Death occurred at 7 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) Victor K. Hager M.D.
22b. ADDRESS 4922 Hampton
22c. DATE SIGNED 1/4/57
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE JAN. 5 1957
23c. NAME OF CEMETERY OR CREMATORY MT. CARMEL CEM.
23d. LOCATION (City, town, or county) BELLEVILLE (State) ILL.
24. FUNERAL DIRECTOR Thomas Kutes ADDRESS 2906 Gravois
25. DATE RECD. BY LOCAL REG. JAN 4 1957
26. REGISTRAR'S SIGNATURE J Earl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. 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

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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 Samuel C Dill

Licensed Embalmer No. 43

P. O. Address 2906 L

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.