FILED JAN 29 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

2781

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 368

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS, Inside Limits Yes X No
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 09 DEPAUL HOSPITAL Length of stay in 1b 2 WKS

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 X
d. STREET ADDRESS (If outside, give location) 3751 Shreve Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First RAYMOND Middle J. Last HARRISON

4. DATE OF DEATH Month Day Year JAN, 12, 1957

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED XX NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH NOV, 15, 1897
9. AGE (In years last birthday) 59 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) WAREHOUSEMAN
10b. KIND OF BUSINESS OR INDUSTRY LUMBER
11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME FRANK T. HARRISON
14. MOTHER'S MAIDEN NAME JENNIE OLDFIELD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WAR 1 & 2 (If yes, give war or dates of service) WAR 1 & 2
16. SOCIAL SECURITY NO. 498-01-3154
17. INFORMANT FRANCES HARRISON Address 3751 SHREVE AVE

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
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) General arteriosclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 331X
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 10, 1957, to Jan 12, 1957 and last saw him alive on Jan 11, 1957
Death occurred at 5:30 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Henry C Westerman, M.D.
22b. ADDRESS 2136 East Grand Ave
22c. DATE SIGNED 1-12-57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 1/15/57
23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY
23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI

24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE
25. DATE RECD. BY LOCAL REG. JAN 14 '57
26. REGISTRAR'S SIGNATURE J Earl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be noted. 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

Westerman
Ga 15169
1368 Grand
1 to 3

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 M. W. Rueter

Licensed Embalmer No. 48

P. O. Address St Louis

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.