

FILED SEP 26 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8685**

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 ST. LOUIS, MO. TOWN		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 1412 Hebert Street	
3. NAME OF DECEASED (Type or print) First Middle Last IDA MELINDA HARDING		4. DATE OF DEATH Month Day Year Sept. 15, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5-1874
9. AGE (In years (birthday)) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (City and state or country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wallace	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Late Milton Handing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ed. Gillihan		Address 1412 Hebert Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTEROSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE DUE TO (b) ARTERIOULAR NEPHROSCLEROSIS DUE TO (c) ARTERIOULAR NEPHROSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHOLELITHIASIS + CHRONIC CHOLECYSTITIS			INTERVAL BETWEEN ONSET AND DEATH 10+ YRS.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 420.0		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> -NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION St. Louis, Mo.		20g. COUNTY St. Louis	
20h. STATE Mo.		20i. DATE OF INJURY 8/28/57	
21. I attended the deceased from Death occurred on 8/28/57 at 1:23 P.M. to 9/15/57 and last saw her/him alive on 9/15/57 on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE R. A. Burmeister M.D.	
22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 9/16/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 18-57	
23c. NAME OF CEMETERY OR CREMATORY St Mathewes Cem.		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.,	
24. FUNERAL DIRECTOR Leidner Und. Co. 2223 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. SEP 17 '57	
26. REGISTRAR'S SIGNATURE Paul Smith MD			

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

7218518

M. I. E. S. Licensed Embalmer No. 3077

P. O. Address St. Louis

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.