

pt. Health,
c. Welfare
Public
Health Service

V. S. 300
Rev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Securing the maximum number of specimens required by 1923-1924 Public Health Service

43058

FILED NOV 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2669

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy 21</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
37 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hilltop House</u>		Length of stay in lb <u>1 MONTH</u>	d. STREET ADDRESS (If outside, give location) <u>4506 Blair Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3/ NAME OF DECEASED. First Middle Last <u>Theresa A Harbaugh</u>			4. DATE OF DEATH Month Day Year <u>Oct. 27. 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3. 1868</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Montgomery Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>William P. Grisham</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Floor</u>		14. NAME OF HUSBAND OR WIFE <u>Edwin H. Harbaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Paul J. Harbaugh 1500 E. Grand</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4500</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. 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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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 <input type="checkbox"/> NOT WHILE 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 COUNTY STATE	
21. I attended the deceased from <u>Aug 1 - 1957</u> to <u>Oct 27 - 1957</u> and last saw her alive on <u>Oct 27 - 1957</u> Death occurred at <u>10:45 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John G McJainey MD</u>			22b. ADDRESS <u>5014 Thekla Av</u>		22c. DATE SIGNED <u>10/28/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10/30/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Stock Mortuary 2117 E. Grand Blvd.</u>			25. DATE RECD. BY LOCAL REG. <u>10-28-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Dornik MD</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr Mc Swinney
5014 9th Street

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 George H. Remelick

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.