

Dept. Health,
Inc., & Welfare
U. S. Public
Health Service

FILED DEC 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45891

STATE FILE NUMBER
12017

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

V. S. 300
Rev. 1-57

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, Missouri Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Length of stay in lb 24 days		d. STREET ADDRESS (If outside, give location) 3506 Caroline Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MAXINE WANDA HARRIS			4. DATE OF DEATH Month Day Year DECEMBER 12, 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1926
9. AGE (In years last birthday) 31		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance	11. BIRTHPLACE (City and state or country) Clarkton, Missouri
12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME Floyd Ferguson	13b. MOTHER'S MAIDEN NAME Eva Walters
14. NAME OF HUSBAND OR WIFE Richard Harris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. ---
17. INFORMANT Address Richard Harris 3506 Caroline 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) RENAL FAILURE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) KIMMELSTEIL-WILSON DISEASE DUE TO (c) DIABETES MELLITUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS		19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE	
21. I attended the deceased from NOV. 19, 1957 to DEC. 12, 1957 and last saw her/him alive on DEC. 12, 1957 Death occurred at 12:40 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. S. Vermillion, M.D.</i> (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 12/13/57		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 12-16-1957		23c. NAME OF CEMETERY OR CREMATORY Our Redeemer Cemetery	
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		24. FUNERAL DIRECTOR ADDRESS Beiderwieden F.H. Inc. 1936 St. Louis Av.	
25. DATE RECD. BY LOCAL REG. DEC 14 57		26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> S.P.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 _____

Licensed Embalmer No. 4530

P. O. Address _____

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.