

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1958

STATE FILE NO. **8622**
REGISTRAR'S NO. **1077**

Registration District No. **318** Primary Registration District No. **1003**

300
-57

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1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
38 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ENROUTE: <u>CITY-HOSP.#1</u> INSTITUTION FROM: <u>2205 N. BROADWAY</u>		Length of stay in 1b <u>35 YRS.</u>	
d. STREET ADDRESS <u>2610 2205 N. BROADWAY</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>HARRISON - WILLIAM - BAYER</u>			4. DATE OF DEATH Month Day Year <u>JAN. 26TH 1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 21ST 1892</u>
9. AGE (In years last birthday) <u>65 YRS</u>		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) <u>LEAD - MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L. MAUL - CO.</u>	11. BIRTHPLACE (City and state or country) <u>EDWARDSVILLE - ILL.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>DIVORCED: (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD-WAR #1</u>		16. SOCIAL SECURITY NO. <u>487-22-5775</u>	
17. INFORMANT Address <u>STANLEY-LADA = 2205 - NO. BROADWAY</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>Coronary Occlusion</u> DUE TO (b) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.1</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
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 Month, Day, Year o.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 COUNTY STATE	
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <u>6:05 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>James W. Seely Deputyl</u>		22b. ADDRESS <u>1300 Clark</u>	
22c. DATE SIGNED <u>1-29-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>JAN. 30TH 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL - CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>JEFFERSON - BARRACKS - MO.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Brockland Und. Co. 1827-HOGAN-ST.</u>	
25. DATE RECD. BY LOCAL REG. <u>JAN 29 58</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith MD</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 Elton R. Remelius

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.