

Health,  
& Welfare  
Public  
Service

S. 300  
1-57

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027811

STATE FILE NUMBER

FILED AUG 11 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2020

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY OR TOWN <b>Pasadena Hills</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Pasadena Hills</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4514 Nadine Ct.</b>		Length of stay in lb <b>years</b>	d. STREET ADDRESS <b>4514 Nadine Ct.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Wilhelmina Nordstrom Harnett</b>			4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1917</b>	9. AGE (In years last birthday) <b>41</b>	FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	11. BIRTHPLACE (City and state or country) <b>Nutley New Jersey</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Malcolm Nordstrom</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Joseph D. Harnett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>yes UNK.</b>		17. INFORMANT Address <b>Joseph D. Harnett 4514 Nadine Court.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of ovaries &amp; metastases</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>1950</b>
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.					
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 <b>October 1957</b> , to <b>July 30, 1958</b> and last saw her/him alive on <b>July 20, 1958</b> Death occurred at <b>11:35 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
21. SIGNATURE <b>Donald E. Kilber M.D.</b>			22b. ADDRESS <b>3121 N. Grand St. Louis 7, Mo.</b>		22c. DATE SIGNED <b>7/24/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>Aug. 2, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Nutley, New Jersey</b>
24. FUNERAL DIRECTOR ADDRESS <b>C.R. Lupton and Sons 7233 Delmar</b>			25. DATE RECD. BY LOCAL REG. <b>8-1-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert P. Donke M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

AIR

COUNTY

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.