

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034296

STATE FILE NUMBER

FILED OCT 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9365

5. 300  
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>4307 West Belle</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle Last <b>Harris</b>			4. DATE OF DEATH Month <b>9</b> Day <b>26</b> Year <b>58</b>		
5. SEX <b>Female</b> <sup>3</sup>	6. COLOR OR RACE <b>Negro</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>21 Aug. 1920</b>	9. AGE (In years last birthday) <b>38</b>	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) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (City and state or territory) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Jeff Thomas</b>		13b. MOTHER'S MAIDEN NAME <b>Mettie Bell</b>	
14. NAME OF HUSBAND OR WIFE <b>Harris</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hortense Grant 4215 E. Page</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 METASTATIC, RT HIP &amp; SACRUM.</b> DUE TO (b) <b>PRIMARY CARCINOMA OF BREAST.</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)		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
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.) <b>170X</b>	
20c. TIME OF INJURY Hour 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 <b>8-26-58</b> to <b>9-26-58</b> and last saw her alive on <b>9-26-58</b> Death occurred at <b>8:50 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Paul H. Larson, M.D.</b>			22b. ADDRESS <b>2601 N. Whittier Street</b>		22c. DATE SIGNED <b>9-26-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>1 Oct. 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
24. FUNERAL DIRECTOR <b>Reliable Funeral Sys. 1389 N. Union</b>			25. DATE RECD. BY LOCAL REG. <b>SEP 30 '58</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>

STATEMENT BY LICENSED EMBALMER

x 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

*John H. Cunningham*

Licensed Embalmer No. *4476*.....

P. O. Address...*H. D. D. Hammett*

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.