

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042637

STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3076

300
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | |
|---|---------------------------------|--|-----------------------------------|---|--|--|---|
| 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> b. COUNTY <u>ST LOUIS</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKWOOD</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>LEMAY 4870</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOSEPH HOSP</u> | | | Length of stay in 1b <u>1 DAY</u> | d. STREET ADDRESS (If outside, give location) <u>970 DAMMERT AV</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>ELNORA</u> Middle <u>---</u> Last <u>HARRIS</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>22</u> Year <u>1958</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MARCH 24 1883</u> | | 9. AGE (In years last birthday) <u>75</u> | |
| | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u> | | IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>CHARLES WURTZ</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CHRISTINE WALK</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>489-20-3414</u> | | 17. INFORMANT <u>MR RAYMOND HARRIS</u> | | Address <u>Rt 14-Box 745 ARFERTON MO.</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>Cerebral hemorrhage, left</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>331X</u> | | | | | | | |
| 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 <u>11-20-58</u> to <u>11-22-58</u> and last saw ^{her} <u>alive</u> on <u>11-22-58</u> Death occurred at <u>9:00</u> <u>am</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Robert W. T. Cheever MD</u> | | | | 22b. ADDRESS <u>P.O. Box 6 Sappington 2340</u> | | 22c. DATE SIGNED <u>11-24-58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>NOV-26-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN Cem</u> | | 23d. LOCATION (City, town, or county) <u>LEMAY, MO</u> | | 23e. (State) | |
| 24. FUNERAL DIRECTOR <u>Fey Funeral Home, MEHNVILLE, MO</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>11-25-58</u> | | 26. REGISTRAR'S SIGNATURE <u>Herbert R. Danke M.D.</u> | |

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 *V E Morris*

Licensed Embalmer No. *33*

P. O. Address *St Louis*

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.