

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001828  
State File No.....

FILED JAN 30 1959

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 159 PRIMARY REG. DIST. NO. 4249 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <b>Jefferson</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, write RURAL and give township) <b>Hillsboro</b>	c. LENGTH OF STAY (in this place) <b>11 Months</b>	c. CITY OR TOWN <b>St. Louis</b> <i>2096</i>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Cedar Grove Nur. Home</b>		e. STREET ADDRESS (If rural, give location) <b>5025 Benedict</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ella</b> b. (Middle) c. (Last) <b>Harrigan</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>January 18th, 1959</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>6-23-1873</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.K.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.K.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>U.K.</b>	13b. MOTHER'S MAIDEN NAME <b>U.K.</b>	14. NAME OF HUSBAND OR WIFE <b>single</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. <b>U.K.</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Ed Walsh 9 Portland Place</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>no</b>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS</b>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Missouri</b>

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>59</b>
22. I hereby certify that I attended the deceased from <b>June 1958</b> to <b>Jan 18, 1959</b> , that I last saw the deceased alive on <b>1-11, 1959</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above.		

23a. SIGNATURE (Degree or title) <b>John W. Waake M.D.</b>	23b. ADDRESS <b>3606 Gravois St. Louis</b>	23c. DATE SIGNED <b>1-18-59</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1-20-1959</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Arthur J. Donnelly 3840 Lindell Blvd.</b>	
DATE REC'D BY LOCAL REG. <b>1-19-59</b>	REGISTRAR'S SIGNATURE <b>Meta Bernard, Reg</b>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

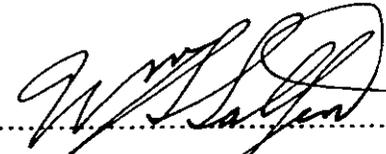
0.300  
0.48

DATE  
JAN 2 3 19

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. 469

P. O. Address 3840 1st

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.