

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003024
STATE FILE NUMBER 297

NEW JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
1-57
6
65

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>UNKNOWN</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Louis City Hosp. #1</i>		Length of stay in lb <i>#1</i>	d. STREET ADDRESS <i>UNKNOWN</i>

3. NAME OF DECEASED (Type or print) First <i>Helen</i> Middle Last <i>Harrington</i>			4. DATE OF DEATH Month <i>1</i> Day <i>8</i> Year <i>59</i>		
--	--	--	--	--	--

5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-12-1877</i>	9. AGE (In years last birthday) <i>81</i>	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) <i>housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>ST CHARLES MO</i>	11. BIRTHPLACE (City and state or country) <i>ST CHARLES MO</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
---	---	--	---

13a. FATHER'S NAME <i>UNKNOWN JOMMON</i>	13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	14. NAME OF HUSBAND OR WIFE <i>HARRY'S HARRINGTON (DECEASED)</i>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>UNKNOWN</i>	17. INFORMANT <i>MARIE CROSSMAN 2471 PARKLAND OVERLAND MO</i>	Address
--	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pyelonephritis - chronic</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<i>600.0</i>
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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	---

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 <i>9-9-58</i> to <i>1-8-59</i> and last saw ^{her} alive on <i>1-8-59</i> Death occurred at <i>10:00 p.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Charles A. Carr M.D.</i> (Degree or title)	22b. ADDRESS <i>1515 Lafayette Ave.</i>	22c. DATE SIGNED <i>1-8-59</i>
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>	23b. DATE <i>1-12-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>OAK GROVE</i>	23d. LOCATION (City, town, or county) (State) <i>ST LOUIS MO</i>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <i>Earl H. Homan OVERLAND MO</i>	25. DATE RECD. BY LOCAL REG. <i>JAN 10 '59</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>
--	---	---

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 

Licensed Embalmer No. 2501

P. O. Address Orlando, Fla.

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.