

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007190

STATE FILE NUMBER

2 1137

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Inside Limits Yes  No   
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. Louis City Hosp. #1** Length of stay in 1b **#1**  
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **MISSOURI** b. COUNTY \_\_\_\_\_  
c. CITY OR TOWN **ST. LOUIS** Inside Limits Yes  No   
d. STREET ADDRESS (If outside, give location) **6261 Gravois** Reside on Farm Yes  No

3. NAME OF DECEASED First Middle Last  
**Fannie Harter**  
4. DATE OF DEATH Month Day Year  
**Jan. 30 1959**

5. SEX **FEMALE** 6. COLOR OR RACE **WHITE** 7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED   
8. DATE OF BIRTH **JAN. 25 1870** 9. AGE (In years last birthday) **87** 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) **HOUSEWIFE** 10b. KIND OF BUSINESS OR INDUSTRY **AT HOME** 11. BIRTHPLACE (City and state or country) **?? WEST VIRGINIA** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **H N K** 13b. MOTHER'S MAIDEN NAME **H N K** 14. NAME OF HUSBAND OR WIFE **DECEASED**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **H N K** 17. INFORMANT Address **EARL A BRAMS 6261 Gravois**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Acute peritonitis**  
DUE TO (b) **Perforated duodenum**  
DUE TO (c) \_\_\_\_\_  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  
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  NO

20a. ACCIDENT SUICIDE HOMICIDE  
    
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.

20d. INJURY OCCURRED WHILE AT  NOT WHILE AT WORK   
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
20f. CITY, TOWN, OR LOCATION COUNTY STATE  
**000**

21. I attended the deceased from **Jan. 28, 1959** to **Jan. 30, 1959** and last saw her/him alive on **Jan. 30, 1959**  
Death occurred **6:40** p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **[Signature]** 22b. ADDRESS **1515 Lafayette Ave.** 22c. DATE SIGNED **1/31/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 23b. DATE **2-2-59** 23c. NAME OF CEMETERY OR CREMATORY **New St. Francis** 23d. LOCATION (City, town, or county) (State) **St. Louis Mo**

24. FUNERAL DIRECTOR ADDRESS **Beezenhan Bros. 6409 Gravois** 25. DATE RECD. BY LOCAL REG. **FEB 2 '59** 26. REGISTRAR'S SIGNATURE **Earl Smith, M.D.**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300  
1-57  
26  
94  
0

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *Van M. Sizemore* .....

Licensed Embalmer No. *4343* .....  
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.