

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-019217
 STATE FILE NUMBER
 2, 1979

FILED JUN 4 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 18 S. Kingshighway Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LEONTINE Middle M Last HARTING			4. DATE OF DEATH Month MAY Day 22 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15-1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 67 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas Barnett		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Walter Harting
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mr. William G. Mellow 10 Twin Springs
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS, SUSPECTED Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) POST-OPERATIVE CHOLECYSTECTOMY FOR CHRONIC CHOLELITHIASIS			INTERVAL BETWEEN ONSET AND DEATH FEW MINUTES YEARS
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4221	
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.		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 APRIL 29, 1959 to MAY 22, 1959 and last saw her alive on MAY 22, 1959 Death occurred at 6:25 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. V. Bradley (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 5/22/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5-23-1959	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory
23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)	
24. FUNERAL DIRECTOR C.R. Lupton & Sons		ADDRESS 7233 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. MAY 22 '59
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

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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

Clarence H. Murray

Licensed Embalmer No. *4016*

P. O. Address *H. Lewis*

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.