

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 4 1959

59-026722

Registration District No. _____ Primary Registration District No. _____ Registrar No. **6854** STATE FILE NUMBER

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| 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 | Length of stay in 1b | c. CITY OR TOWN St. Louis | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1427 Bremen ave | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First DEBBIE Middle MARIE Last HARRINGTON | | | 4. DATE OF DEATH Month July Day 22 Year 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-22-1959 | 9. AGE (last birthday) 0 | IF UNDER 1 YEAR Months 0 Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) St. Louis Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |

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| 13a. FATHER'S NAME Frank Harrington | 13b. MOTHER'S MAIDEN NAME Jeanne Thompson | 14. NAME OF HUSBAND OR WIFE none |
| 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. none | 17. INFORMANT Address Mr. Frank Harrington 1427 Bremen ave |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatal atelectasis | | INTERVAL BETWEEN ONSET AND DEATH ? |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Prematurity | |
| | DUE TO (c) 762.5 | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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. Month, Day, Year _____ | | |

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|--|--|---|--------------------------|
| 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.) Routine prenatal care | 20f. CITY, TOWN, OR LOCATION Bloomfield, Missouri | COUNTY _____ STATE _____ |
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21. I attended the deceased from **6-59** to **7-22-59** and last saw her/him alive on _____
Death occurred at **2:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Raymond A. Staunton MD | 22b. ADDRESS 3121 N. Grand | 22c. DATE SIGNED 7-23-59 |
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|---|-----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE July 25, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Bloomfield Cemetery | 23d. LOCATION (City, town, or county) Bloomfield, Missouri |
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| 24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE | 25. DATE RECD. BY LOCAL REG. JUL 23 1959 | 26. PROTESTANT SIGNATURE Stan Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision. _____

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 4520

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.