RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-030463

STATE FILE NUMBER

...D VS AUG 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7625

DED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Lutheran
Inside Limits: Yes ☐ No ☐

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): 6429 Idaho.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Benjamin Middle: F Last: Harris.

4. DATE OF DEATH: Month: August Day: 15 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: Jul.1,1877

9. AGE (last birthday): 82

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REtired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Columbus Ohio

12. CITIZEN OF WHAT COUNTRY: USA.

13a. FATHER'S NAME: David Harris.

13b. MOTHER'S MAIDEN NAME: Not Known.

14. NAME OF HUSBAND OR WIFE: Alma Harris.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT: Alma Harris Address: 6429 Idaho.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Adenocarcinoma prostate

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 177X

INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

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 a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ 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

21. I attended the deceased from 7/15/59, to present 8/15/59 and last saw her/him alive on 8/15/59.
Death occurred at 9 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Herbert D. Lund MD

22b. ADDRESS: 4652 Maryland

22c. DATE SIGNED: 8/17/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 8-19-1959

23c. NAME OF CEMETERY OR CREMATORY: St.Paul Church Yard.

23d. LOCATION (City, town, or county) (State): St. Louis County.

24. FUNERAL DIRECTOR ADDRESS: Southern Funeral Home 6322 S. Grand Blvd.

25. DATE RECD. BY LOCAL REG.: AUG 17 '59

26. REGISTRAR'S SIGNATURE: Karl Smith, M.D. G.R

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

Dr. Herluf G.Lund.
4652 Maryland Ave.
2-5 PM.

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 John J. Haine

Licensed Embalmer No. 4108

P. O. Address St Louis

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