

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030465

FILED VS SEP 11 1959

2 7932

STATE FILE NUMBER

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 <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4437 Wilcox</u>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence V. Harris</u>	4. DATE OF DEATH Month Day Year <u>Aug. 25, 1959</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white 60</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Joseph Anderson</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Schmitt</u>	14. NAME OF HUSBAND OR WIFE <u>Frank K. Harris</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT Address <u>Frank K. Harris 4437 Wilcox</u>
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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) <u>CARDIAC ARREST</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CARDIAC ASTHMA</u>	
	DUE TO (c) <u>434.2</u>	

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 checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 1956 to 8/20/59 and last saw him alive on 8/24/59
Death occurred at 510 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>D. Michael M.D.</u>	22b. ADDRESS <u>812 Olive St. Louis</u>	22c. DATE SIGNED <u>8/26/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>8-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SS Peter & Paul</u>	23d. LOCATION (City, town, or county) (State) <u>Waterloo, Ill.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 27 '59</u>	26. REGISTRAR'S SIGNATURE <u>W. J. Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. _____

P. O. Address _____

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.