

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1959

59-030468

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **7380**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO 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 type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MISSOURI BAPTIST HOSP			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2843rd OSAGE		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MILDRED Middle HARRISON Last				4. DATE OF DEATH Month AUG Day 6 Year 1959					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH JULY 3 1902		9. AGE (last birthday) 57 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PSYCHIATRIC AIDE			10b. KIND OF BUSINESS OR INDUSTRY STATE HOSPITAL		11. BIRTHPLACE (City and state or country) MISSOURI U-S-A		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME ANDREW SCHAUB			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE FRED H. HARRISON			
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.		17. INFORMANT Address FRED H. HARRISON 2843rd OSAGE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Nephritis DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 4 WKS over 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Pelvis with Metastases to Bones						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			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____		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	
21. I attended the deceased from 4/8/57 to 8/6/59 and last saw her ^{him} alive on 8/6/59 Death occurred at 3:35 PM 8/8/59 m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Mrs. Mary Nakada (Degree or title) <i>Mary Nakada</i>				22b. ADDRESS Medical West Bldg 950 Francis St				22c. DATE SIGNED 8/7/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE AUG 10 1959		23c. NAME OF CEMETERY OR CREMATORY BETHANY CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS MO			
24. FUNERAL DIRECTOR Thomas Kutia 2906 Gravois				25. DATE RECD. BY LOCAL REG. AUG 8 '59		26. REGISTRAR'S SIGNATURE Boal Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RM 107

5-30-70

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 James C. Dull

Licensed Embalmer No. 4347

P. O. Address 2906

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.