

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034784

FILED OCT 13 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2590

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST LOUIS</u>	b. COUNTY <u>ST LOUIS</u>	a. STATE <u>MISSOURI</u>	b. COUNTY <u>ST LOUIS</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEMAY</u>	Length of stay in 1b <u>18 yrs</u>	c. CITY OR TOWN <u>LEMAY</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital give location) HOSPITAL OR INSTITUTION <u>9523 So BROADWAY</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>9523 So BROADWAY</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>JOSEPH</u>	Middle <u>Y.</u>	Last <u>HARRIS</u>	4. DATE OF DEATH	Month <u>Sept</u>	Day <u>27</u>	Year <u>1959</u>
--	------------------------	---------------------	-----------------------	-------------------------	----------------------	------------------	---------------------

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>FEB-14-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
------------------------------	---	---	---	--	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP TV SERVICE</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	---	---

13a. FATHER'S NAME <u>JAMES HARRIS</u>	13b. MOTHER'S MAIDEN NAME <u>HAZEL HARRIS CRISMAN</u>	14. NAME OF HUSBAND OR WIFE <u>HAZEL HARRIS CRISMAN</u>
--	---	---

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>490-22-8040</u>	17. INFORMANT <u>Mrs HAZEL RANCH</u>	Address <u>608 ARBOL AVE ARCADIA, CALIFORNIA</u>
--	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Cerebral Hemiparalysis</u>	<u>ATONIC</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Thrombosis</u>	<u>ATONIC</u>
	DUE TO (c) <u>Cerebral Sclerosis</u>	<u>5 years</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 type="checkbox"/> No <input type="checkbox"/> Unknown

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 <u></u> a.m. <u></u> p.m.	Month, Day, Year
--	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 2-22-59 to 9-27-59 and last saw her alive on 9-25-59
Death occurred at 6:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John B. Crawford D.O.</u>	22b. ADDRESS <u>9612 S. Broadway</u>	22c. DATE SIGNED <u>9-30-59</u>
---	--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT-1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN Cem.</u>	23d. LOCATION (City, town, or county) <u>LEMAY, MO</u>	(State)
---	---------------------------------------	--	--	----------------

24. FUNERAL DIRECTOR <u>Fey Funeral Home</u>	ADDRESS <u>MEHLVILLE MO</u>	25. DATE RECD. BY LOCAL REG. <u>9-30-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
--	---------------------------------------	---	--

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W E Morris

Licensed Embalmer No. 3360

P. O. Address St Louis

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.