

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038280

FILED VS NOV 2 1959 17

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2539 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>ST. LOUIS</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ROBINSON CLAYTON</b>		Length of stay in 1b <b>D.O.A.</b>		c. CITY OR TOWN <b>ROBERTSON</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS COUNTY HOSP</b>				Inside Limits No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>239 Highland</b>	
3. NAME OF DECEASED (Type or print) First <b>RACHEL</b> Middle Last <b>HARRIS</b>				4. DATE OF DEATH Month <b>9</b> Day <b>21</b> Year <b>59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLOR</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/98</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>KEO ARK</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>HENRY POLK</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give year or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>NON</b>		17. INFORMANT <b>Alma Lee Harris</b>		Address <b>3044 Lucas</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown Natural Causes</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)							
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 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 _____, to _____ and last saw her/him alive on _____ Death occurred at <b>10:49 a</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Type or print) <b>John C. Murphy MD Asst. Health Commissioner</b>				22b. ADDRESS <b>801. S. Brentwood Clayton, Mo.</b>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9/25/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON PARK</b>		23d. LOCATION (City, town, or county) (State) <b>BERKLEY 21 MO</b>		
24. FUNERAL DIRECTOR <b>PRICE FUNERAL HOME 2829 Washington</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-23-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>		

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 Edward A. Flynn

Licensed Embalmer No. 4444

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.