

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-041922

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **210577**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri.</b>		Length of stay in 1b <b>35 years</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5600 Arsenal Street.,</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>E.</b> Last <b>Hargrove</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>9/16/1878</b>	9. AGE (last birthday) <b>81</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Verinda Pratt</b>		11. BIRTHPLACE (City and state or country) <b>Missouri.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Clark Thompson</b>			13b. MOTHER'S MAIDEN NAME <b>Verinda Pratt</b>		14. NAME OF HUSBAND OR WIFE <b>B. F. Hargrove, dec'd</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Nil</b>	17. INFORMANT <b>Mrs. F. H. Allums, Shreveport, Louisiana.</b>			Address
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>Fractured right hip</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>904.7</b> <b>45</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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. <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 checked="" 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.) <b>Suffered in fall at Chronic</b>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, hotel, office bldg., etc.) <b>131 1/2 St. Louis Mo</b>			20e. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>	COUNTY	STATE	
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, hotel, office bldg., etc.) <b>131 1/2 St. Louis Mo</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>	COUNTY	STATE			
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Gatrel Taylor Carnes</b>				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>11/16/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/26/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Centuries Park Memorial</b>		23d. LOCATION (City, town, or county) <b>Shreveport, Louisiana.</b>			(State)
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 16 1959</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, 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

      , Student Embalmer No.       

working under my personal supervision.

Student       

Signature of Student Embalmer

Signed Lawrence O. Gerling

Licensed Embalmer No. 4279

P. O. Address St. Louis

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.