URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-041931

FILED VS DEC 11 1959

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 211123 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. — Length of stay in 1b: over 7 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN St. Louis, Mo. — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1047 Sells Ave., — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle — Last HARRIS
4. DATE OF DEATH: Month Nov. Day 29, Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-2[illegible]-14
9. AGE (last birthday): 45 — 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): formerly: Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U. S.A.
13a. FATHER'S NAME: David Harris
13b. MOTHER'S MAIDEN NAME: Ada Fowler
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Ruth Morgan — Address: 1047 Sells Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonitis, bilateral interstitial
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cardiac hypertrophy with left ventricular dilatation & congestive failure
DUE TO (c) Chronic cholecystitis & cholelithiasis
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) 584x
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Sept. 3, 1952, to Nov. 29, 1959 and last saw ~~her~~ him alive on Nov. 29, 1959
Death occurred at 6:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. Hofstatter, M.D. (Degree or title) — L. Hofstatter M.D.
22b. ADDRESS 5400 Arsenal St.
22c. DATE SIGNED 11-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE 12/2/59
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county): St. Louis County (State): Mo.

24. FUNERAL DIRECTOR: Buchholz Mortuary — ADDRESS: 5967 W. Florissant
25. DATE RECD. BY LOCAL REG.: DEC 1 1959
26. REGISTRAR'S SIGNATURE: Hard Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. 4557

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp
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.