

**URU DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS JAN - 8 1960**

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**212045**

STATE FILE NUMBER

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

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</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2901 Delmar</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle Last <b>Harris</b>				4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>59</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/13/96</b>		9. AGE (last birthday) <b>63</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>10</b>		IF UNDER 24 HR Hours <b>10</b> 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>none</b>		11. BIRTHPLACE (City and state or country) <b>Lake Providence, La. U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY				
13a. FATHER'S NAME <b>Thomas Rose</b>				13b. MOTHER'S MAIDEN NAME <b>Adeline Sewell</b>				14. NAME OF HUSBAND OR WIFE <b>Columbus Harris</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>Unknown</b>		17. INFORMANT Address <b>Columbus Harris, 2901 Delmar</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>Arteriosclerotic Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>4200</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cardiac Insufficiency</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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 _____ 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 <b>12-22-59, 7:17 p.m.</b> <b>12-23-59</b> and last saw her <input checked="" type="checkbox"/> alive on <b>12-23-59</b> Death occurred at <b>8:45</b> p. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Robert J. ...</i>					22b. ADDRESS <b>2601 N. Whittier St.</b>					22c. DATE SIGNED <b>12-28-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12/28/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>						
24. FUNERAL DIRECTOR ADDRESS <b>Charles J. Gates, 4107 Finney Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 28 1959</b>		26. REGISTRAR'S SIGNATURE <i>Loal Smith M.D.</i> <i>mjb</i>							

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 *Augustine Severa*

Licensed Embalmer No. 4580

P. O. Address 4107 Finney Av

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.