

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

**-60-003510**

Registration District No. **2 91960**

Primary Registration District No.

Registrar's No.

**396**

STATE FILE NUMBER

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>1454 Francis</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle Last <b>Harris</b>			4. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>60</b>												
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</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>3/27/76</b>		9. AGE (last birthday) <b>83</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>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Columbus, Miss.</b>				12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>					
13a. FATHER'S NAME <b>Henry Amos</b>				13b. MOTHER'S MAIDEN NAME <b>Mary</b>				14. NAME OF HUSBAND OR WIFE <b>Arron Harris</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Alice Greenleaf 1454 Francis</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>Hypertensive Cardiovascular Disease</b> DUE TO (b) DUE TO (c) <b>443 x</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</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>12-8-59</b> to <b>1-8-60</b> and last saw <sup>her</sup> alive on <b>1-8-60</b> Death occurred at <b>11:40 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <b>H. B. Koone</b>						22b. ADDRESS <b>2601 N. Whittier St.</b>				22c. DATE SIGNED <b>1-8-60</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1/15/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson</b>				23d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Missouri</b>							
24. FUNERAL DIRECTOR <b>H. B. Koone</b>				ADDRESS <b>1221 North Grand</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 12 1960</b>		26. REGISTRAR'S SIGNATURE <b>Neal 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Martin Blackburn*

Licensed Embalmer No. *396*

P. O. Address *1221 N. Sha*

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.