JRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS FEB 25 1960

-60-008311

STATE FILE NUMBER

NDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1467

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis, Mo.

Length of stay in 1b: 1 yr. 2 mo. 19 days

c. CITY OR TOWN: St. Louis, Mo.

Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St.Louis State Hospital

Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 3915 Folsom Av.

Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)
First: BESSIE Middle: Helen Last: HARRIS

4. DATE OF DEATH Month: Feb. Day: 5, Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 11-29-22

9. AGE (last birthday): 37 yrs.

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: Shoe factory

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): ? Arkansas

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Charles Spicer

13b. MOTHER'S MAIDEN NAME: Laura Richards

14. NAME OF HUSBAND OR WIFE: William W. Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 429-14-7324

17. INFORMANT: William Harris, 3915 Folsom

Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Bilateral interstitial pneumonitis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Pulmonary edema, acute

DUE TO (c): 525X

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. ☐ 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 Nov. 17, 1958, to Feb. 5, 1960 and last saw her/him alive on Feb. 5, 1960

Death occurred at 11:45 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF John H. McMahan, M.D.

22a. SIGNATURE (Degree or title): John H. McMahan M.D.

22b. ADDRESS: 5400 Arsenal St.

22c. DATE SIGNED: 2-5-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 2/8/60

23c. NAME OF CEMETERY OR CREMATORY: St. Trinity Cem.

23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR: McLAUGHLIN'S, 2301 Lafayette

ADDRESS

25. DATE RECD. BY LOCAL REG.: FEB 8 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____

Licensed Embalmer No._____

P. O. Address_____

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