

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008313

FILED VS FEB 25 1960

2 1901

STATE FILE NUMBER

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

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i> | | Length of stay in 1b <i>70 YRS.</i> | c. CITY OR TOWN <i>ST. LOUIS</i> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>PARK LANE HOSP.</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <i>2654 NAT'L BRIDGE</i> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) <i>KATHERINE HARRIS</i> | | | 4. DATE OF DEATH Month <i>2</i> Day <i>15</i> Year <i>1960</i> | | | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <i>10/1/1889</i> | 9. AGE (last birthday) <i>70</i> | |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i> | | 11. BIRTHPLACE (City and state or country) <i>ST. LOUIS, MO.</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | |
| 13a. FATHER'S NAME <i>UNK. TRINKLER</i> | | | 13b. MOTHER'S MAIDEN NAME <i>UNK.</i> | | | 14. NAME OF HUSBAND OR WIFE <i>CHARLES HARRIS</i> | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT Address <i>JOHN E. CHRISTIAN 2654 NAT'L BRIDGE</i> | |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral hemorrhage</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Intertrochanteric fracture of the left femur</i> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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.) <i>Fell at home in basement.</i> | | |
| 20c. TIME OF INJURY <i>11:30-12:00 p.m.</i> | Hour | Month | Day | Year <i>1/13/60</i> | |

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| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>2654 National Bridge St. Louis Mo.</i> | |
| 21. I attended the deceased from <i>Jan. 14, 1960</i> to <i>Feb. 15, 1960</i> and last saw her/him alive on <i>Feb. 15, 1960</i> Death occurred at <i>10:27 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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| 22a. SIGNATURE (Degree or title) <i>William H. Grundmann, M.D.</i> | | 22b. ADDRESS <i>634 N. Grand St., St. Louis 3</i> | | 22c. DATE SIGNED <i>2/16/60</i> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | 23b. DATE <i>2-19-60</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>NEW BETHLEHEM</i> | | 23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS COUNTY, MO.</i> | |
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| 24. FUNERAL DIRECTOR ADDRESS <i>SUEDMEYERSONS 3934 N. 20TH ST.</i> | | 25. DATE RECD. BY LOCAL REG. <i>FEB 18 1960</i> | 26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> | | |
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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 *Robert M. Murray*

Licensed Embalmer No. 3749

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.