

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 23 1960

60-011557

Registration District No. 160 Primary Registration District No. 559 Registrar's No. 44

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Festus</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>3 1/2 Yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mt. View Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>6269 Natural Bridge</b>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>HARDING</b> Last			4. DATE OF DEATH <b>Mar. 15, 1960</b> Month Day Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>3-17-84</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours 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	11. BIRTHPLACE (City and state or country) <b>Montivido, Minn</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Bernard Jahn</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown Wright</b>		14. NAME OF HUSBAND OR WIFE <b>Frank W. Harding</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>None</b>	17. INFORMANT <b>Harold Harding, 6269 Natural Bridge Mo</b>	Address <b>St. Louis,</b>
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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) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input 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 8-2-59 to 3-15-60 and last saw her <sup>him</sup> alive on 3-15-60  
Death occurred at 3:55 P. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>A. A. Donnell, M.D.</b> (Degree title)	22b. ADDRESS <b>112 Mississippi Ave. Crystal City, Mo.</b>	22c. DATE SIGNED <b>3-17-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-18-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>
23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		(State)
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>3-17-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DOCUMENT

MEDICAL CERTIFICATION

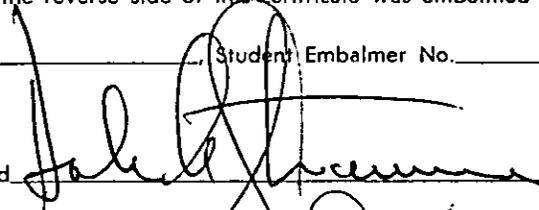
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

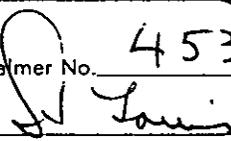
MAR 20 1967

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. 4533

P. O. Address  \_\_\_\_\_

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.