

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS APR 25 1960

2 4171-60-016898
 STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo		c. CITY OR TOWN St Louis Mo	
Length of stay in 1b _____		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. City Hospital		d. STREET ADDRESS (If outside, give location) _____	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle A Last Harkins			4. DATE OF DEATH Month 4 Day 15 Year 60
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-10-96
		9. AGE (last birthday) 63	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)		10b. KIND OF BUSINESS OR INDUSTRY Unemployed	11. BIRTHPLACE (City and state or country) St Louis Mo
			12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John J. Harkins		13b. MOTHER'S MAIDEN NAME Mary T. Cain	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) War #1		16. SOCIAL SECURITY NO. 491-16-8391	17. INFORMANT Edward J. Harkins Address 3969A Shenandoah Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
DUE TO (c) _____		331x
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 type="checkbox"/> No <input type="checkbox"/> Unknown

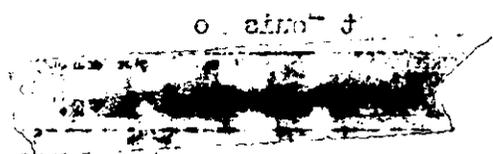
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____.
 Death occurred at **10:00 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick E. Taylor Coroner	22b. ADDRESS 1300 Clark Ave	22c. DATE SIGNED 4/16/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-18-1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
		23d. LOCATION (City, town, or county) (State) St Louis Mo

24. FUNERAL DIRECTOR Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd	25. DATE RECD. BY LOCAL REG. APR 16 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D. (H.T.)
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF



of the State of
Illinois, to-wit:

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 *W. C. Sagan*

Licensed Embalmer No. 4699
P. O. Address 3846 Lind

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.