

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

**-60-017876**

XC 17098524 R# AL102

31 FILED VS APR 29 1965 00

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **1283**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MISSOURI</b>		Length of stay in lb <b>85 Days</b>	c. CITY OR TOWN <b>ST. LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8355A HALLS FERRY ROAD</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN WALKER HARRIS</b>			4. DATE OF DEATH Month Day Year <b>APRIL 17, 1960</b>		
---	--	--	---	--	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-96</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Engr. Supply Co.</b>	11. BIRTHPLACE (City and state or country) <b>FAYETTE, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	--	--	---

13a. FATHER'S NAME <b>JOHN T. HARRIS</b>	13b. MOTHER'S MAIDEN NAME <b>LOU E. JENNINGS</b>	14. NAME OF HUSBAND OR WIFE <b>NEVER MARRIED</b>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (if yes, give war or dates of service) <b>YES WW-I</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>MARY E. MINOR (SISTER)</b> Address <b>8355A Halls Ferry St. Louis, Mo.</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>APLASTIC ANEMIA</b>	INTERVAL BETWEEN ONSET AND DEATH <b>UNDET.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>292.4H</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) <b>CARCINOMA OF PROSTATE</b>	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 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. attended the deceased from <b>1-13-60</b> to <b>4-17-60</b>	Death occurred at <b>11:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.
---	--

22a. SIGNATURE <b>W. Oppler</b> (Degree or title) <b>W. OPPLER, MD, Director Professional Services, Vet Adm Hosp, Jeff Brks, Mo.</b>	22b. ADDRESS	22c. DATE SIGNED
---	--------------	------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>4/21/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Pleasant Cemetery New Franklin, Mo.</b>	23d. LOCATION (City, town, or county) (State)
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>4-19-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
---	---------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

X

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed Flavio M. B. B.

Licensed Embalmer No. 4375  
P. O. Address St. Louis, 23, 11

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.