

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025395

STATE FILE NUMBER

FILED VS JUN 20 1960

317

Registration District No. 500

Primary Registration District No. 1708

INDEXED

1. PLACE OF DEATH a. COUNTY Manchester, Mo. (St. Louis Co.)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Manchester, Mo.		Length of stay in 1b 14 Months		c. CITY OR TOWN Clayton, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pine Crest Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 225 North Meramec Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Helen Middle Harris Last Harris				4. DATE OF DEATH Month May Day 29 Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1875		9. AGE (last birthday) 84 yr.		IF UNDER 1 YEAR Months 0 Days 8		IF UNDER 24 HR Hours 8 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY HOME			11. BIRTHPLACE (City and state or country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY U. S. A.				
13a. FATHER'S NAME Cornelius Kelleher				13b. MOTHER'S MAIDEN NAME Mary Flynn				14. NAME OF HUSBAND OR WIFE Will Harris					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 493-10-258-00		17. INFORMANT Address Mrs. Dale Dunn 4065 Fillmore, St. Louis							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic - cardiac - vascular disease & chronic brain syndrome										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)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) fibrosis ② myofibrils of scalp										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.) none									
20c. TIME OF INJURY Hour 8:45 a.m. Month, Day, Year 5-29-60		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 4-2-59 to 5-29-60 and last saw her alive on 5-24-60 Death occurred at 8:45 a.m. 5-29-60 on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Allen M. Dearney M.D.						22b. ADDRESS 4308 Epeter St. Louis Co 14 Mo			22c. DATE SIGNED 5-31-60				
23a. BURIAL CREMATION OR OTHER DISPOSITION burial		23b. DATE June 1, 1960		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION (City, town, or county) (State) St. Louis, Mo.						
24. FUNERAL DIRECTOR Louis H. Bopp Inc. Kirkwood, Mo.				25. DATE RECD. BY LOCAL REG. 5-31-60		26. REGISTRAR'S SIGNATURE John E. Murphy M.D.							

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

Francis J. Wyland Jr.

Licensed Embalmer No. *4512*

P. O. Address *Kirkwood, Mo.*

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.