

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-083194

LED VS SEP 7 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2553 STATE FILE NUMBER

DED

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>Clayton</b>		Length of stay in 1b <b>DOA</b>	c. CITY OR TOWN <b>University City</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>St. Louis County Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7752 Wild Plum Lane</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Shirley</b> Middle <b>Alice</b> Last <b>Harden</b>			4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/26/1913</b>	9. AGE (last birthday) <b>47</b>	IF UNDER 1 YEAR 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 <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Chillicothe, Ohio.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>George Skinner</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown Throckmorton</b>		14. NAME OF HUSBAND OR WIFE <b>Leo J. Harden</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>235-03-5205</b>	17. INFORMANT <b>Leo J. Harden, 7752 Wild Plum Lane</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>Gunshot wound of head</b>		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)		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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Self inflicted gunshot wound of head</b>
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20c. TIME OF INJURY <b>2:00 a.m.</b>	Month, Day, Year <b>8/29/60</b>
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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.) <b>Living-room of apt.</b>	20f. CITY, TOWN, OR LOCATION <b>University City</b>	COUNTY <b>St. Louis</b>	STATE <b>Missouri</b>
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_, and last saw her/him alive on \_\_\_\_\_.  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Raymond K. Hand</i>	(Degree or title) <b>Coroner</b>	22b. ADDRESS <b>Clayton, Mo.</b>	22c. DATE SIGNED <b>9/1/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-29-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOCAL</b>	23d. LOCATION (City, town, or county) (State) <b>Chillicothe, Ohio.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>8-29-60</b>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

