

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 7 1960

-60-033382
STATE FILE NUMBER

UNDEED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2349

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	c. CITY OR TOWN Richmond Hgts. 17, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Shamrock Nurs. Home		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7427 Arlington Dr. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HAROLD Middle LESLIE Last GARLAND			4. DATE OF DEATH Month Aug. Day 3, Year 1960				
5. SEX M	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1904	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months 14 Days 14 Hours Min. 	IF UNDER 24 HR Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Sup.		10b. KIND OF BUSINESS OR INDUSTRY Hillmath O Bada		11. BIRTHPLACE (City and state or country) Orion Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Clarence Garland			13b. MOTHER'S MAIDEN NAME Carrie Jones		14. NAME OF HUSBAND OR WIFE Isabelle Garland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 337-22-2912		17. INFORMANT Address Isabelle Garland 7427 Arlington Dr.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral thrombosis (embolic)	unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Convalescent lobe atony	unknown
	DUE TO (c) Pulmonary tuberculosis	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary fibrosis & emphysema		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	
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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 Month, Day, Year s.m. p.m. 			

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
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21. I attended the deceased from **July 16, 1960** to **Aug 3, 1960** and last saw him alive on **Aug 1, 1960**
Death occurred at **11:40 p** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lewis Littmann MD	22b. ADDRESS 8231 Clayton Rd (17)	22c. DATE SIGNED 8/5/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 6, 1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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24. FUNERAL DIRECTOR ADDRESS A.H. Bocklage F.H. 6536 Clayton Rd.	25. DATE RECD. BY LOCAL REG. 8-5-60	26. REGISTRAR'S SIGNATURE J. M. [Signature]
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(Licensed Embalmer's Statement on Reverse Side)

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 Robert M. Murra

Licensed Embalmer No. 3749

P. O. Address St Louis

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.