

IDED

1. PLACE OF DEATH a. COUNTY		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 St. Louis		Length of stay in 1b	c. CITY OR TOWN Clayton
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7611 Carondelet Ave
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth D. Harrison			4. DATE OF DEATH Month Day Year Oct. 28, 1960	
5. SEX Female	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 10/20/1873	9. AGE (last birthday) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME William D. Harrison		13b. MOTHER'S MAIDEN NAME Mary Jane McGowan.		14. NAME OF HUSBAND OR WIFE	
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. no		17. INFORMANT Address Mrs. Margret Ross; 7611 Carondelet	

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 Several Yrs. Several Yrs.
IMMEDIATE CAUSE (a) Chronic myocardial			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertensive Heart Disease		
DUE TO (c) 443*			
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 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.)	
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. I attended the deceased from **Oct 19 - 59-59** to **Oct 28 - 1960** and last saw her **alive on Oct 28 - 60**
 Death occurred at **5:30 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. S. Brown	(Degree or title) MD	22b. ADDRESS 3903 Olive	22c. DATE SIGNED 10/31/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/31/1960	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.
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24. FUNERAL DIRECTOR C.R. Lupton & Sons; 7233 Delmar Blvd	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE Roald Smith. M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. H. H. H. H.
3902
11:00 To 1:00 Noon

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoer

Licensed Embalmer No. 386

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign 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.