

318 Primary Registration District No. 1003 Registrar's No. 1578

AMENDED

Registration District No. 318
FILED VS MAR 1 1961

| | | | | | |
|--|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in 1b 3 Days | c. CITY OR TOWN East St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS 2016 Bond Avenue | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First COREAN Middle NMN Last HARRELL | | | 4. DATE OF DEATH Month FEBRUARY Day 14 Year 1961 | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7/4/97 | 9. AGE (last birthday) 63 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Charleston, S. C. | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13a. FATHER'S NAME RICHARD LYDE | | 13b. MOTHER'S MAIDEN NAME MANDY WASHINGTON | | 14. NAME OF HUSBAND OR WIFE WHITMON HARRELL | |
| 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. Unknown | 17. INFORMANT Whitmon Harrell, 2016 Bond Avenue, E. 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) MASSIVE INTRACEREBRAL HEMORRHAGE | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 HOURS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CEREBRAL VASCULAR ARTERIOSCLEROSIS | | | | | YEARS |
| DUE TO (c) 33/x | | | | | |
| 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 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. I attended the deceased from AUG. 28, 1958 to FEB. 14, 1961 and last saw her/him alive on FEB. 14, 1961 Death occurred at 11:55 R.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <i>C. S. McMillan, M.D.</i> (Degree or title) M. D. | | | 22b. ADDRESS BARNES HOSPITAL | | 22c. DATE SIGNED 2/15/61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2/19/61 | 23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens | | 23d. LOCATION (City, town, or county) Stokey Township, Ill. (State) | |
| 24. FUNERAL DIRECTOR <i>Marion's Office</i> | | ADDRESS 2114 Missouri Ave. East St. Louis, Ill. | 25. DATE RECD. BY LOCAL REG. FEB 16 1961 | 26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> | |

DATE AMENDED

INSTEAD OF DOCUMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Frank Prokopff

Licensed Embalmer No. 4356

P. O. Address St. Louis, Mo

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.