

DATE AMENDED
 AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. Louis</i>		Length of stay in 1b	c. CITY OR TOWN <i>ST. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>916 N. 16 ST</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>916 N. 16 ST</i>
3. NAME OF DECEASED (Type or print) First <i>Bennie</i> Middle Last <i>Harris</i>		4. DATE OF DEATH Month <i>Mar</i> Day <i>13</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>negro</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 5, 1923</i>
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ret</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <i>37</i>
11. BIRTHPLACE (City and state or country) <i>Ark</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Henry Harris</i>		13b. MOTHER'S MAIDEN NAME <i>Gracy ?</i>	14. NAME OF HUSBAND OR WIFE <i>Single</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	17. INFORMANT Address <i>Bertha Benion 5333 Easton</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage.</i> DUE TO (b) _____ DUE TO (c) <i>331X</i>			INTERVAL BETWEEN ONSET AND DEATH
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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ <i>10:00 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree of authority) <i>Paul J. Simon coroner</i>		22b. ADDRESS <i>300 Clark</i>	22c. DATE SIGNED <i>3/14/61</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>3-20-1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cem</i>	23d. LOCATION (City, town, or county) (State) <i>St Louis Co MO</i>
24. FUNERAL DIRECTOR ADDRESS <i>F. de Green 4214 Nelson</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 15 1961</i>	26. REGISTRAR'S SIGNATURE <i>Roal Smith, M.D.</i>

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 F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.