SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-022650
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5769

FILED JUN 29 1961

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

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Incarnate Word Hosp.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Montgomery
c. CITY OR TOWN: New Florence Mo.
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): New Florence Mo.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Ibbia Middle: Ann Last: Harrison
4. DATE OF DEATH: Month: June Day: 18 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9-4-1880
9. AGE (last birthday): 80
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HR: 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: Home
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Frank McAilster
13b. MOTHER'S MAIDEN NAME: Mary McMasyers
14. NAME OF HUSBAND OR WIFE: Elmer Harrison
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Thelma onkle Address: 4148 Peeping

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Passive Congestion — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) arteriosclerotic heart Disease — 2 yrs
DUE TO (c) 420.0
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 April 5, 1959 to June 18, 1961 and last saw her/him alive on June 18, 1961
Death occurred at 8 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. Dworkin MD
22b. ADDRESS: 1657 So Grand
22c. DATE SIGNED: 6-20-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: June 21, 1961
23c. NAME OF CEMETERY OR CREMATORY: Antioch Cemetery
23d. LOCATION (City, town, or county) (State): Lodi Missouri

24. FUNERAL DIRECTOR: McLaughlin ADDRESS: 2301 Lafayette Ave
25. DATE RECD. BY LOCAL REG.: JUN 20 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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_____ Signed H. G. Farris

Signature of Student Embalmer

Licensed Embalmer No. 3384

P. O. Address St. Louis

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.