

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4507
Registrar's No. 1337

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH: FEB MAR 12 1940
(a) County St. Louis, Mo
(b) City or town St. Louis, Mo
(c) Name of hospital or institution: BARNES HOSPITAL
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 7 days
In this community 6 months
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 21
(If outside city or town limits, write "RURAL")
(d) Street No. 929 N. 23RD STREET
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME MANDY GRIFFIN
3. (b) If veteran, name war -
3. (c) Social Security No. -

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 5
year 1940 hour 5:36 minute A M.
21. I hereby certify that I attended the deceased from January 30, 1940, to February 5, 1940
that I last saw her alive on February 5, 1940
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife W. B. Harkness
6. (c) Age of husband or wife if alive - years
7. Birth date of deceased SEPT. 5, 1879
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage - RT. internal capsule & left hemiplegia
Due to Hypertension
Due to Chronic glomerular nephritis

8. AGE: Years 60 Months 5 Days 0
If less than one day hr. min.

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy central hemorrhage - RT. internal capsule

9. Birthplace Wadena, Ark
(City, town, or county) (State or foreign country)
10. Usual occupation House-work
11. Industry or business Own Home
12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Ida Bell Wilson
(b) Address Wadena, Ark
17. (a) Burial (b) Date thereof Feb. 11, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Crystal City, Mo
18. (a) Signature of funeral director Walter R. Vallette
(b) Address Crystal City, Mo
19. (a) FEB 9 1940 (b) _____
(Date received local registrar) (Signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W. Anderson (M. D. or other) _____
Address BARNES HOSPITAL Date signed 2-6-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Juste J. ...

*Have not called for
2-9-46*

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.....

Gentry R. Palitte....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Gentry R. Palitte

Licensed Embalmer No. *3481*

P. O. Address *Crystal City, 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 this body is not embalmed, above space should be left blank.