

FILED FEB 11 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3633**  
Registrar's No. **0993**

**318**

**1003**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>4 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2039</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Incarnate Word Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>3 6215 Bowman Ave.</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Harold</b>		b. (Middle) <b>Edward</b>		c. (Last) <b>Quirk</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 27 1953</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Mar. 8, 1899</b>		9. AGE (In years less birthday) <b>53</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mts. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinery Co.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Hannibal, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Partick Quirk</b>		13b. MOTHER'S MAIDEN NAME <b>Rose Hayes</b>		14. NAME OF HUSBAND OR WIFE <b>Josephine Quirk</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-09-2503</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Josephine Quirk 6215 Bowman Ave.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>331X</b>			
22. I hereby certify that I attended the deceased from <b>Jan 1948</b> , to <b>26 Jan 1953</b> , that I last saw the deceased alive on <b>26 Jan 1953</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>C. H. Caton</b>				23b. ADDRESS <b>2705 Clinton</b>		23c. DATE SIGNED <b>27 Jan 53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Jan. 29, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JAN 28 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Hoffmeister Colonial Mortuary</b>		ADDRESS <b>6464 Chippewa St., St. Louis, Mo.</b>	

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

Dr. A. F. Catanzaro  
2715 Clifton Ave.,  
HI 2517

**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 \_\_\_\_\_  
Student Embalmer

Signed

*Harry J. Scheemaker*

Licensed Embalmer No. *2679*

P. O. Address *7814 S. Broadway*

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, fact should be so stated above.