

FILED SEP 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27768

State File No.

6621

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo		c. LENGTH OF STAY (in this place) 4 Days		c. CITY OR TOWN St. Louis Mo		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital				e. STREET ADDRESS (If rural, give location) 436 Holly Hills			
3. NAME OF DECEASED (Type or Print) a. (First) Molly			b. (Middle) _____			c. (Last) Harstick	
4. DATE OF DEATH (Month) (Day) (Year) July 29 1955			5. SEX Females		6. COLOR OR RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH June 4 1862		9. AGE (In years last birthday) 93		IF UNDER 1 YEAR: Months _____ Days _____	
IF UNDER 1 YEAR: Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Columbia Ill	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Milton Smith		13b. MOTHER'S MAIDEN NAME Mollie Morgan		14. NAME OF HUSBAND OR WIFE John (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. 489-09-5215		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease senility DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of Rt Hip				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19a. DATE OF OPERATION 7/28/55		19b. MAJOR FINDINGS OF OPERATION Pinned Rt Hip 4200F					
20a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) (STATE) St. Louis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-25-55 m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fall in Home			
22. I hereby certify that I attended the deceased from 1950 , to July 29, 1955 , that I last saw the deceased alive on 7/29, 1955 , and that death occurred at 9:40 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Jos. Granato M.D.				23b. ADDRESS 5521 S. Padua		23c. DATE SIGNED 7/30/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/2/55		24c. NAME OF CEMETERY OR CREMATORY New St Marcus Cem		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. AUG 1 1955		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Schumacher 3013 Meramec			

M.D. (Licensed Embalmer's Statement on Reverse Side)

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

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..... *Jack Haupt*

Licensed Embalmer No. *47*

P. O. Address..... *St. Paul*

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.