

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037623

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9265** STATE FILE NUMBER

<b>FILED SEP 19 1963</b>	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>St. Louis</b></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3928 Parker</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>Missouri</b></p> <p>c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <b>3928 Parker</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED First Middle Last <b>KATHERINE HARSCH</b></p>	
<p>4. DATE OF DEATH <b>9-15-1963</b> Month Day Year</p>	
<p>5. SEX <b>Female</b></p>	<p>6. COLOR OR RACE <b>White</b></p>
<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>8-3-1888</b></p>
<p>9. AGE (last birthday) <b>75</b></p>	<p>IF UNDER 1 YEAR Months Days Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>At Home</b></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b></p>
<p>11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b></p>	<p>12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b></p>
<p>13a. FATHER'S NAME <b>Frederick Harsch</b></p>	<p>13b. MOTHER'S MAIDEN NAME <b>Katherine Jouika</b></p>
<p>14. NAME OF HUSBAND OR WIFE <b>NONE</b></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>NO</b></p>	<p>16. SOCIAL SECURITY NO. <b>NONE</b></p>
<p>17. INFORMANT <b>Frank Harsch</b> Address <b>3928 Parker L6</b></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden onset</b>)</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>332x</b> DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21: I attended the deceased from <b>Jan 1962</b> to <b>9/15/63</b> and last saw her/him alive on <b>9/14/63</b></p> <p>Death occurred at <b>5 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <b>Ralph Berg M.D.</b></p>	<p>22b. ADDRESS <b>32038 Grand</b></p>
<p>22c. DATE SIGNED <b>9/15/63</b></p>	
<p>23a. BURIAL, CREMATION, (Specify) <b>Burial</b></p>	<p>23b. DATE <b>9;17-1963</b></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul Cem</b></p>	<p>23d. LOCATION (City, town, or county) (State) <b>ST. Louis Mo.</b></p>
<p>24. FUNERAL DIRECTOR <b>WINGBERMUEHLE</b> ADDRESS <b>3819 So Grand Blvd</b></p>	<p>25. DATE RECD. BY LOCAL REG. <b>SEP 16 1963</b></p>
<p>26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b></p>	

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AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 SHOULD READ  
 BY AFFIDAVIT OF

DOCUMENT  
 MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

**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

*George J. Stembermalle*

Licensed Embalmer No. 4611

P. O. Address St Louis 18 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.