MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

26173

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. Barnard Hospital St. ..... Ward)

File No. ..... Registered No. 17845

2. FULL NAME Esther Harris

(a) Residence. No. 2929 Lucas St., 21 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not Known

7. AGE: Years about 25; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

PARENTS

10. NAME OF FATHER: Walter Bland
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER: Ida Utley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

14. INFORMANT: R. McMyler
(Address) 3427 Washington

15. FILED SEP 3 1927 19 Mar C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-30-27 19

17. I HEREBY CERTIFY, That I attended deceased from 8-16-27, 19..., to 8-30-27, 19..., that I last saw her alive on 8-30-27, 19..., and that death occurred, on the date stated above, at 1150 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infected ovarian cyst & ovarian abscess due to infection cause unknown Non Malignant Cyst. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Post operative shock 139R 139A (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? home

DID AN OPERATION PRECEDE DEATH? yes DATE OF 8-30-27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Operation

(Signed) James Knott, M. D

, 19 (Address) Barnard Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Washington Park
DATE OF BURIAL: 9-3-1927

20. UNDERTAKER: W S Wade Mnd Co
ADDRESS: 4202 Finney

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.