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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 28864

Township ..... Primary Registration District No. ..... Registered No. 8420

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

2. FULL NAME Ralph Harris

(a) Residence. No. 3968 W Ferdinand St. 11 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 17 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): —

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 17 - 1926

7. AGE: YEARS 1 | MONTHS 5 | DAYS 3 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Thomas Harris
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Daisy Nix
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... Mo
(STATE OR COUNTRY)

14. Hospital Information
INFORMANT E. Roman
(Address) City Hospital

15. FILED SEP 21 1927 19 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 20 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1927, to Sept 20, 1927, that I last saw him alive on Sept 20, 1927, and that death occurred, on the date stated above, at 1 15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute gastro-enteritis

11 9/12 1/3 B (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Edmund R. Sheridan M.D.
9/20, 1927 (Address) City 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: Neelyville Mo
DATE OF BURIAL: Sept 22nd 1927

20. UNDERTAKER: Cullen Kelly
ADDRESS: 4526 Easton

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.

THIS IS A PERMANENT RECORD

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