

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

Do not use this space.

8806

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. _____
 Township Ray Primary Registration District No. _____ Registered No. _____
 City Kansas City (No. _____) Summit Lutheran St. (Ward _____)

2. FULL NAME

Baby Harris
 (a) Residence No. 26 Wood St. 4 Ward _____ (If nonresident give city or town and State)
 (Usual place of abode) W. Calcutt apt.
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 2, 1928

7. AGE: YEARS MONTHS DAYS IF LESS (than 1 day, 4 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) none
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER R.H. Harris
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Doniphan
 (STATE OR COUNTRY) Mo.
 12. MAIDEN NAME OF MOTHER Mell Robertson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Hermitage
 (STATE OR COUNTRY) Mo.

14. INFORMANT Mary Robertson
 (Address) 109 W 89th

15. FILED 3-3-28 M.M. Crane
 REGISTRAR asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 2, 1928

17. I HEREBY CERTIFY, That I attended deceased from _____ 1928, to _____ 1928 (that I last saw him alive on _____, 1928, and that death occurred, on the date stated above, at _____)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Atelectasis
154
161A (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY Prematurity 7 1/2 mo.
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 161A
 IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) [Signature], M. D.
3/3, 1928 (Address) 404 Bryant St

*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 Mont Rose Mo DATE OF BURIAL 3/5 1928
 ADDRESS _____

20. UNDERTAKER Sumner Mortuary
42 nd + 13th mo

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.

