

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

Do not use this space.

1. PLACE OF DEATH

County *St. Anthony Hosp.*
Township
City *St. Louis Mo.* (No. *St. Anthony's Hosp.*)

Registration District No. *751*
Primary Registration District No. *1003*

File No. *14887*
Registered No. *3790*
St. _____ Ward _____

2. FULL NAME

Albert Harrel
(a) Residence. No. _____ St. *16* Ward. *Troy Mo.*
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED—HUSBAND OF (OR) WIFE OF <i>Lillie</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>July 2 - 1860</i>		
7. AGE <i>67</i>	YEARS <i>9</i>	MONTHS <i>2</i>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Farmer</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 4 - 1928*
17. I HEREBY CERTIFY That I attended deceased from *3-6-* 19*28*, to *4-4-* 19*28* (that I last saw h. *alive* on *4-25-* 19*28*, and that death occurred, on the date stated above, at *8:50 P.* m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sub-Phrenic Abscess
unknown (duration) yrs. mos. da.
CONTRIBUTORY *Carcinoma Pancreas* (SECONDARY)
unknown (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? *HA*
IF NOT AT PLACE OF DEATH:
DID AN OPERATION PRECEDE DEATH? *yes* DATE of *3-10-28*
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS? *operation & laboratory*
(Signed) *Dr. S. W. Kay and Taylor*, M. D.
, 19 (Address) *Uni. Club Bldg.*

*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.

9. BIRTHPLACE (CITY OR TOWN) *Lincoln Co. Mo.*
(STATE OR COUNTRY)
PARENTS
10. NAME OF FATHER *William*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Virginia*
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER *Geneva Harrel*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Virginia*
(STATE OR COUNTRY)

14. INFORMANT *Sister M. Paschal*
(Address) *St. Anthony's Hosp.*
15. FILED *5* 1928 *May 2* 1928
REGISTRAR *H. L. Forbush*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Troy Mo* DATE OF BURIAL *April 6 1928*
20. UNDERTAKER *H. L. Forbush* ADDRESS *Winfield*

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.

