

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

Do not use this space.

36242

1. PLACE OF DEATH

County Calloway Registration District No. 104
 Township Fulton Primary Registration District No. 3008
 City Fulton (Name) St. Jefferson City Mo (Ward)

File No. _____
 Registered No. 209

2. FULL NAME

Eula Harris
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 20 ds. How long in U.S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
32 _____ _____ _____

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

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

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT Med. certificate
 (Address) _____

15. Nov 19 1928 R. N. Crews
 FILED _____ REGISTRAR

7 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 1928
 17. I HEREBY CERTIFY That I attended deceased from Sept 25th 1928 to Nov 15, 1928
 that I last saw him/her on Nov 15, 1928 and that death occurred on the date stated above, 6:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis
2 1/2 (duration) yrs. _____ mos. _____ ds.
34 (duration) yrs. _____ mos. _____ ds.

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

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Smear Lab.
 (Signed) E. E. Taylor M. D.
 _____, 19 (Address) State Hospital

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Jefferson City Mo DATE OF BURIAL 11-18-1928

20. UMBERTAKER C. P. Heinrich ADDRESS 26. Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. R.—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.

