

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

Do not use this space.

39802
5209

399

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. St. Joseph Hosp)

Registration District No.
Primary Registration District No. 1002

File No.
Registered No.
St. Ward

2. FULL NAME

Louis Harris

(a) Residence, No. 1126 Indep. St. 1 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U.S., if of foreign birth? 40 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Sarah Harris

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

Unknown

7. AGE

YEARS MONTHS DAYS
About 50

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work junk Dealer
(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) Russia

10. NAME OF FATHER

Hersch Harris

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Russia

12. MAIDEN NAME OF MOTHER

Sarah (?)

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Russia

14.

INFORMANT A. N. Marks
(Address) 3611 Indep Ave

15.

FILED 11/3/28 19 28 M. M. Curran REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 1 19 28

17. Coroner
I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19....., that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
131

930 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 1126 Indep
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) H. B. Moore M.D.

11-1, 19 28 (Address) Coroner

*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 Sheffield **DATE OF BURIAL** 11-4 19 28

20. UNDERTAKER J. P. Lewis **ADDRESS** City

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.

WHITE PLAINLY, WITH OBTAINING INFORMATION

