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

Do not use this space.

9004

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1903

City St. Louis (No. City Hospital #2 St. ..... Ward)

File No. ..... Registered No. 2947

2. FULL NAME James Harden

(a) Residence. No. 3232 Lawton St., 21 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 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: Col.
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) Nov. 16, 1903

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
25	3	11	

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) (STATE OR COUNTRY) Ark.

PARENTS

10. NAME OF FATHER Louis Harden
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Roxie J. Bush
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ark

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED MAR -7 1929 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-27- 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-23-, 1929, to 2-27-, 1929 that I last saw him alive on 2-27-, 1929, and that death occurred, on the date stated above, at 8:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Miliary Tuberculosis
37A

(duration) yrs. 2 1/2 mos. ds.

CONTRIBUTORY (SECONDARY) 37a

(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? X-ray
(Signed) T. E. Cunningham, M.D.
, 19 (Address) 2945 Lawton

*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: Pine Bluff Ark
DATE OF BURIAL: 3-7- 1929

20. UNDERTAKER: Peoples End Co
ADDRESS 3100 Franklin

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.

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