

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

Do not use this space.

13398

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis* (No. *City Hosp. #2*)..... St. Ward)

File No.
Registered No. **4017**
St. Ward)

2. FULL NAME

Mollie Harris
(a) Residence No. *1116 no. Jefferson Ave.* St., *M* Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U.S., if of foreign birth *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>		4. COLOR OR RACE <i>Colored</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>James Harris</i>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Apr 21, 1887</i>					
7. AGE	YEARS	MONTHS	DAYS	if LESS than 1 day, ... hrs. or ... min.	
<i>47</i>	<i>11</i>	<i>19</i>			
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <i>Laundress</i>					
(b) General nature of industry, business, or establishment in which employed (or employer) <i>Private family</i>					
(c) Name of employer <i>Mrs. Ross</i>					
9. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) <i>St. Louis Missouri</i>					
10. NAME OF FATHER <i>Louis Cunningham</i>					
11. BIRTHPLACE OF FATHER (CITY OR TOWN), (STATE OR COUNTRY) <i>Hubbards Alabama</i>					
12. MAIDEN NAME OF MOTHER <i>Jessie Aught</i>					
13. BIRTHPLACE OF MOTHER (CITY OR TOWN), (STATE OR COUNTRY) <i>Callaway Co. Mo.</i>					
14. INFORMANT <i>Lizzie Panel Sister</i> (Address) <i>1007 Morgan St.</i>					
15. FILED <i>Mar 21 1929</i> REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) *3/28* 19*29*

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... and that I last saw him alive on 19....., and that death occurred, on the date stated above, at *10:20 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis - Hypertrophied Heart *13!*

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *1/29* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *1/29*

IF NOT AT PLACE OF DEATH.....

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

20. WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Wm. T. Dwyer* (M.D.)

44 . 19*29* (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 <i>Fisher Dickson Cemetery</i>	DATE OF BURIAL <i>Apr 4 1929</i>
20. UNDERTAKER <i>Metropolitan Bur. Home</i>	ADDRESS <i>3529 Lucas</i>

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

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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