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

Do not use this space.

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**1. PLACE OF DEATH**

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. City Hosp # 2 St. 4622 Ward)

File No. .....

Registered No. .....

**2. FULL NAME** Charley Harris

(a) Residence. No. 3049 Clarence St., 10 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 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) March 7, 1922

7. AGE: Years 7 | Months 1 | Days 11 | If LESS than 1 day, ..... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER L. C. Harris

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

12. MAIDEN NAME OF MOTHER Eva Westbrooks

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

14. INFORMANT L C Harris
(Address) 3049 Clarence Ave.

15. FILED APR 27 1929 Max C Starkey REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/18 1929

17. 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 1:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock and Cerebral Haemorrhage
Struck by Auto
2 10 M (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) St Louis Mo.
Criminal Carelessness (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner M.D.
4/19 1929 (Address) Dep Coro

*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: Greenwood
DATE OF BURIAL: 4/28 1929

20. UNDERTAKER: R. M. C. Green
ADDRESS: 3517 Laclede ave.

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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