

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

Do not use this space.

26014

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis Washlat** (No. **2**) City **Washlat** (No. **42**)

File No.....
Registered No. **7201**
St..... Ward)

2. FULL NAME

Roberta Harris
(a) Residence. No. **2725 A Washington** St., **21** Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **9** yrs. **0** mos. **0** ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE Colored	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 27 - 1893				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
35	00	11	10	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work House wife				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) **Jonestown Alb.**
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER Jim Carbis
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) don't know (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER don't know
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) don't know (STATE OR COUNTRY)

14. INFORMANT **Lillie Gates**
(Address) **9725 A Washington**

15. FILED **1929** **Washlat** REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July - 2 - 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 **943 B** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Memorize + laceration of Brain (fractured skull) due to falling from window at 2725 Washington at about 2:40 A.M. (duration) yrs. mos. ds. 186A
CONTRIBUTORY **accidents** (SECONDARY) **1929 B** (duration) yrs. mos. ds. **824 a**

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY **Y**
WHAT TEST CONFIRMED DIAGNOSIS **Autopsy**
(Signed) **W. H. Hurler** M. D.
7/5 1929 (Address) **20**

*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 **Washington Park** DATE OF BURIAL **July 9 1929**
20. UNDERTAKER **Dement - son** ADDRESS **2700 Wash st.**

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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