

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

Do not use this space.

26666

1. PLACE OF DEATH

County..... Registration District No. *780*
 Townshp..... Primary Registration District No. *1000*
 City *St. Louis, no City Hospital #2* St. (Ward)

2. FULL NAME

Henry Harrison
 (a) Residence. No. *3101 Sheridan* St. *21* Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred *52* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No.
 Registered No. *7947*
 St. (Ward)

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 *single*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *3-4-1861*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 4 25
 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) *Ill* (STATE OR COUNTRY)
 10. NAME OF FATHER *Gay Harrison*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *N.Y.* (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER *Lucy Hamilton*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *no* (STATE OR COUNTRY)

14. INFORMANT *A. Gertrude Creath* (Address) *City Hospital #2*
 15. FILED *19-1-1929* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *7-29-1929*
 17. I HEREBY CERTIFY, That I attended deceased from *7-18-1929* to *7-29-1929*, 19*29* that I last saw him alive on *7-29-1929* and that death occurred, on the date stated above, at *7 A.M.*
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
465
131
Cancer of Stomach
 (duration) *1* yrs. mos. ds.
 CONTRIBUTORY *chr nephritis*
 (SECONDARY) (duration) *6* yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? *no* DATE OF
 WAS THERE AN AUTOPSY? *no*
 WHAT TEST CONFIRMED DIAGNOSIS *fluoroscopic + laboratory*
 (Signed) *A. E. Hale*, M. D.
7/29/29 (Address) *city Hospital #2*
 *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 *8-1 1929*
 20. UNDERTAKER *Perment - son* ADDRESS *2700 Wash*

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.

237
2

