

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

Do not use this space.

27662

3351

**1. PLACE OF DEATH**

County St. Louis  
Township W. 1st  
City St. Louis

Registration District No. 399  
Primary Registration District No. 2002

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Burne Harris  
(a) Residence. No. 609 Kansas St., Ward. ....

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Male      **4. COLOR OR RACE** negro      **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widow  
(specify the word)

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** Widow

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Unknown

**7. AGE**      YEARS      MONTHS      DAYS      IF LESS than 1 day,      hrs.      or      min.  
about 62

**8. OCCUPATION OF DECEASED**  
(a) Trade, profession, or particular kind of work Labour  
(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)** Kentucky

**10. NAME OF FATHER** Burne Harris

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

**12. MAIDEN NAME OF MOTHER** Unknown

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

**14. INFORMANT (Address)** Emma Harris 609 Kansas

**15. FILED** 8/5/24 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 8-2-24

**17. I HEREBY CERTIFY**, that I attended deceased from ..... 19....., and that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Haemorrhage  
87

**CONTRIBUTORY (SECONDARY)** 74/01  
(duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**  
IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH? .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy  
(Signed) Dr. Turner, M. D.

(Address) Deputy 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** Maple Hill Cemetery      **DATE OF BURIAL** 8-5-24

**20. UNDERTAKER** Hel. Art. Fickler      **ADDRESS** 1709 Vine

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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