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

Do not use this space.

29134

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 8261

City St Louis Mo. (No. St Johns Hosp. St. ..... Ward)

2. FULL NAME Lulu Madge Harrison

(a) Residence. No. 3101 Kimberley Av St., 6 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	—

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 24 1929

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	1	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(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 Robert Harrison

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

12. MAIDEN NAME OF MOTHER Hazel Goodrum

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

14. INFORMANT Robert Harrison
(Address) 3101 Kimberley Av

15. FILED AUG 12 1929 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 1929

17. I HEREBY CERTIFY, That I attended deceased from August 5th, 1929, to August 10, 1929 that I last saw her alive on August 10, 1929, and that death occurred, on the date stated above, at 2-15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Entero-Colitis
117
15X (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) Malnutrition
(duration) ..... yrs. 1 mos. ..... ds.

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

(Signed) J. M. Brown, M.D.
Aug 11, 1929 (Address) 2867a Union Blvd.

*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	DATE OF BURIAL
Jordon Ky.	Aug. 12 1929
20. UNDERTAKER	**ADDRESS**
Duhman Harrel	1905 Union

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.

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