

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

Do not use this space.

35942

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St Louis mo**

(No **St Louis Baptist Hospital**)

File No. **10773**

Registered No. ....

St. .... Ward)

**2. FULL NAME** **Wm. James Harmer**

(a) Residence No. **2351 Alton Pl.** St. **23** 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widower**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **2-24-1868**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....	
				hrs.	min.
<b>61</b>	<b>8</b>	<b>17</b>			

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) (STATE OR COUNTRY) **Canada**

10. NAME OF FATHER **Andrew Harmer**

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

12. MAIDEN NAME OF MOTHER **unknown**

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

14. INFORMANT **P. A. Lewis**  
(Address) **2314 Park Ave**

15. FILED **NOV 4 1929** **Wm C Stork** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10-31 1929**

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to..... 19....., that I last saw him..... alive on..... 19....., and that death occurred, on the date stated above, at **5:00 P.** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Chronic Myocarditis**  
**92%** (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Chronic Endocarditis**  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **POW**  
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. Kemmer M.D.**  
**11/4 29** (Address) **Dep. Comm**

\*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 **New St Marcus** DATE OF BURIAL **11-4 1929**

20. UNDERTAKER **McLaughlin 1631 mo ave**

AGE should be stated EXACTLY. PHYSICIAN should be classified. Exact statement of OCCUPATION is very important. Some information should be stated in plain terms, so that it can be understood.

17

20-24-1868

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No.....  
 Township St. Louis Primary Registration District No. 1003 Registered No. 10773  
 City St. Louis (No. ....) St. .... Ward.....

**2. FULL NAME**

Wm James Harmer  
 (a) Residence No. .... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

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

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work..... (duration) ..... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) ..... yrs. .... mos. .... ds.  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 19 Max C Jordan REGISTRAR  
JAN 30 1939

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 31 1929

17. No physician in attendance  
 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..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Coroner M.D.  
125, 1930 (Address) St. 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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

**SUPPLEMENTARY**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION'S very important. PARENTS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1929  
35942