

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

Do not use this space.

40708

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No. Prinity Luther 002)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 5113  
St. \_\_\_\_\_ Ward)

**2. FULL NAME**

William Roswell Harris  
(a) Residence No. 833 W. 71st St., 8 Ward.  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Maude P. Harris

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 16, 1871

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
58      1      16

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Traveling Salesman  
(b) General nature of industry, business, or establishment in which employed (or employer) American  
(c) Name of employer Thread Co.

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

10. NAME OF FATHER Wm. H. Harris

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

12. MAIDEN NAME OF MOTHER Eliza Paine

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

14. INFORMANT Mrs. Maude P. Harris  
(Address) 833 W. 71st St.

15. FILED 12/29 m.m. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 12 1929

17. I HEREBY CERTIFY, That I attended deceased from 12/4, 1929, to 12/12, 1929, that I last saw him alive on 12/13, 1929, and that death occurred, on the date stated above, at 7:25 AM.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

a acute myocardial infarction following operation on gall bladder  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 121B  
127B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 130

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. S. Hulet, M.D.

\*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 Cledo, Ohio DATE OF BURIAL 12/13 1929

20. UNDERTAKER Greenman Mortuary ADDRESS 104 W. 42nd St.

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.



**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. 399

File No. ....

Township .....

Primary Registration District No. 1002

Registered No. 5113

City K. City (No. ....)

St. .... Ward)

2. FULL NAME

William Roswell Harris

(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 M (write the word)

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  
(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)

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 12/29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 12 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... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Nephritis following operation on bladder appendix  
Contributory Infected gall bladder  
(SECONDARY) Cholelithiasis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) 1170 M. D. , 19 (Address)

\*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

19

SUPPLEMENTARY

N. B.—Every item of information 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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