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

Do not use this space.

6479

1. PLACE OF DEATH

County ..... Registration District No. 2701

Township ..... Primary Registration District No. 11003

City St. Louis, Mo. (No. City Hospital #2 St. ..... Ward)

File No. .....

Registered No. 1290

2. FULL NAME Randolph Harris

(a) Residence. No. 1318 no. 15th St., 25 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 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: col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/1/1884

7. AGE: YEARS 45 — MONTHS 4 — DAYS 3 — If LESS than 1 day, ... hrs. or ..... min.

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): Odd Jobs
(c) Name of employer

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

PARENTS

10. NAME OF FATHER: Scott Harris
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): unknown

14. INFORMANT: A. Gertrude Creath
(Address) City Hospital #2

15. FILED ..... 19.. Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4- 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-31- 1930 to 2-4- 1930 that I last saw him alive on 2-4- 1930 and that death occurred, on the date stated above, at 5 30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
59
93C (duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (SECONDARY) Diabetes mellitus
57 (duration) 1 yrs. — mos. — ds.

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

0 DID AN OPERATION PRECEDE DEATH? NO DATE OF —

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A E Hale, M. D.

2/4/ 1930 (Address) City Hosp. #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: Washington Park
DATE OF BURIAL: 2/7 1930

20. UNDERTAKER: Ellis Jones
ADDRESS: 2700 Wash st

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

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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