

MAY 28 1930

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

Do not use this space.

13818

1. PLACE OF DEATH

County *St. Louis*Registration District No. *784*Township *St. Bernard*Primary Registration District No. *6030*City *St. Louis*(No. *30 Boyd Ave*)

File No.

Registered No.

St. Ward)

2. FULL NAME *Archie Harris Harris*(a) Residence, No. *30 Boyd Ave* 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

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 8-1938*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

—

—

24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Child

(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)

Mo

10. NAME OF FATHER

Archie Harris

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Not known*12. MAIDEN NAME OF MOTHER *Emma Douglas*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill

14.

INFORMANT

(Address)

*Emma Douglas
30 Boyd Ave St. Louis*

15.

FILED

5/27/30 O. N. Schulte M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-29-30*

17.

I HEREBY CERTIFY, That I attended deceased from *4/25*19. to *4/29* 19*30*that I last saw him alive on *4/25*, 19*30* and that death occurred, on the date stated above, at *4:25* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Broncho-Pneumonia**10 1/2*

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

100%

(duration) yrs. mos. ds.

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) *W. R. Harris*, 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

DATE OF BURIAL

Greenwood Cemetery 5-2-30

20. UNDERTAKER

ADDRESS *4202**W. R. Harris*
Timney

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.

