

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

Do not use this space.

17282

1. PLACE OF DEATH

County St. Louis
 Township Carondelet
 City Koch

Registration District No. 1123
 Primary Registration District No. 5248 B
 (No. Koch Hosp.)

File No. _____
 Registered No. 164
 St. _____ Ward)

2. FULL NAME George Harris

(a) Residence. No. 4166 McRee St. _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred X yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7 1867

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>62</u>	<u>10</u>	<u>19</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Lead miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS	10. NAME OF FATHER <u>George Harris</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Missouri</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Sarah Laws</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Mo</u> (STATE OR COUNTRY)

14. INFORMANT Koch Hospital Records
(Address) Koch Mo.

15. FILED 5/26 30 L. C. Obroy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28, 1930

17. I HEREBY CERTIFY, that I attended deceased from April 24, 1930 May 26, 1930 that I last saw him alive on May 26, 1930, and that death occurred, on the date stated above, at 2:20 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23H
31
 About (duration) 1 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Tuberculosis of Liver
 About (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray & Sputum
(Signed) R. E. Rose, M. D.

(Address) Koch Hospital

*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

Flat River Mo DATE OF BURIAL 5-28 1930

20. UNDERTAKER

Ealdwell Bros. ADDRESS Flat River Mo

