

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

Do not use this space.

19598

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kau Primary Registration District No. 2
 City Kansas City (No. General Hospital No. 2) St. _____ Ward _____

2. FULL NAME Harrison, Erno
 (a) Residence No. 1710 C 13th St. Ward 2
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 17 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14, 1878

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	52	0	6	

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) Douglas Co
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Harrison Henry

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

12. MAIDEN NAME OF MOTHER Miss Oline

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

14. INFORMANT Record Clerk
 (Address) Gen Hosp #2

15. FILED 6/23 1930 M. M. Crowe
 REGISTRAR asor

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1930

17. I HEREBY CERTIFY, That I attended deceased from June 19, 1930, to June 20, 1930 that I last saw him alive on June 20, 1930, and that death occurred, on the date stated above, at 5:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial decompensation
92A
93D (duration) yrs. mos. ds.
 CONTRIBUTORY mitral insufficiency
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF BIRTH _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Physical
 (Signed) Howard M. Smith M. D.
June 20, 1930 (Address) Gen. Hosp No 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 Highland DATE OF BURIAL June 22 1930
 20. UNDERTAKER Huttmann Bros ADDRESS 1729 Lydie

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.

