

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

Do not use this space.

34367

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo** (No. **1921 Carr St**)

File No.

Registered No. **9724**

St. Ward)

2. FULL NAME **Bora Harris**

(a) Residence. No. **1921 Carr St** St. **21** 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 **Female** 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 **Jules Harris**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Unknown**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **About 43**

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work **Domestic** (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) **Ark.**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Annie White**

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

14. INFORMANT **Anthony Harris** (Address) **1921 Carr St**

15. FILED **OCT 12 1930** **May E. Starkeoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 8 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 24**, 19**30**, to **Oct 8**, 19**30**, that I last saw him alive on **Oct 7**, 19**30**, and that death occurred, on the date stated above, at **10 A** m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septic Peritonitis

Intestinal Cancer (duration) yrs. mos. **9** ds.

CONTRIBUTORY (SECONDARY) **Intestinal Cancer** (duration) yrs. **3** mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH **at home**

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **clinical**

(Signed) **August Mulla**, M. D.

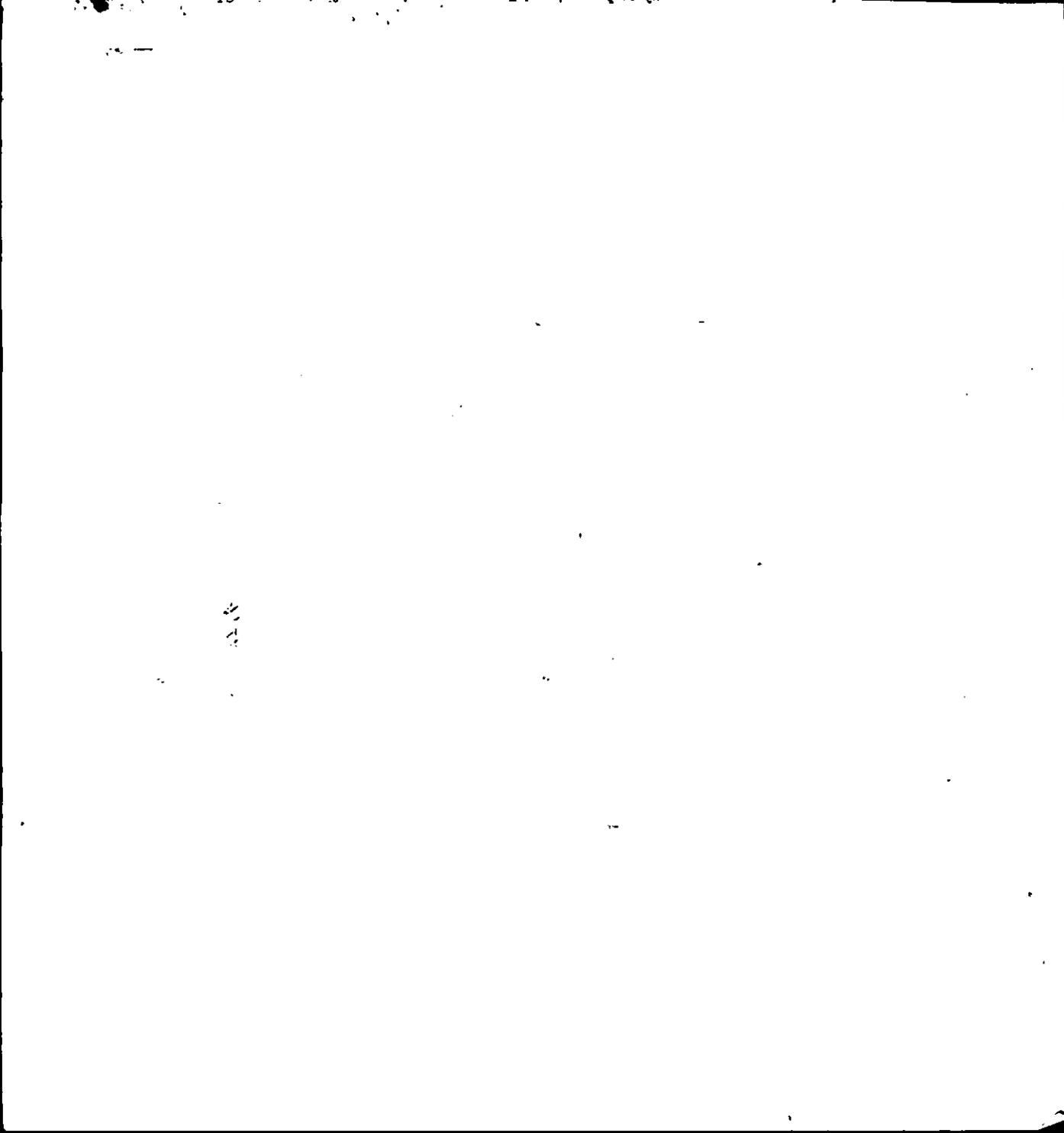
X 11, 19**30** (Address) **27 1/2 Frank**

*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 **Father Dickerson** DATE OF BURIAL **Oct 12 1930**

20. UNDERTAKER **James and Co.** ADDRESS **1418 Jefferson**

B. M. Dickerson



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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County 1921 Carr St.

Registration District No.

File No.

Township

Primary Registration District No.

Registered No.

City Saint Louis Mo. (No.) St. Ward)

2. FULL NAME Cora Harris

(a) Residence. No. 1921 Carr St., Ward. (If nonresident, give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>col</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 Giles Harris

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7th 1882

7. AGE <u>44</u> YEARS	MONTHS <u>3</u>	DAYS <u>1</u>	If LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED Domestic

(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) Ark. in Country
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>unknown</u> (STATE OR COUNTRY) <u>Dicie Woods</u>
	12. MAIDEN NAME OF MOTHER <u>?</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>unknown</u> (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED, 19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 8 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1930 to Oct 8 1930 that I last saw h. or alive on Oct 8 1930, and that death occurred, on the date stated above, at 7:10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic Peritonitis
(duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY) Intestine Carcinoma
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Vincent J. Mueller, M. D.

X-8- .19 30 (Address) 2385 Franklin

*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 <u>Father Dickson Cemetery</u>	DATE OF BURIAL <u>Oct. 12 1930</u>
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20. UNDERTAKER James and Tanner 1418 N. Jefferson
ADDRESS St. Louis Mo.

S-(2)31367

**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.....
Township.....
City, St. Louis (No.....)

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 9724
St..... Ward.....

2. FULL NAME

Cora 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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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,hra. ormin.

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 11. 1933 Mrs. C. Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 8 1930

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic peritonitis

CONTRIBUTORY (SECONDARY) Intestinal Cancer
Primary seat unknown submation
given over to me by Dr. Mueller

18. WHERE WAS DISEASE CONTRACTED air of Dr. 12-10-30

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19 (Address) 407

*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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COPIED

SUPPLEMENTARY

S-(2)31367