

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

Do not use this space.

2943

1. PLACE OF DEATH

County.....
Township.....
City St Louis (No. 1003)

Registration District No. 791
Primary Registration District No. 1003

File No. 86
Registered No. 86
St. _____ Ward)

2. FULL NAME

Robert Harrelson

(a) Residence. No. 12 Sterling Ave St. 12 Ward. St. Louis Co Mo
(Usual place of abode) River View Garden (If nonresident, give city or town and State)
Length of residence in city or town where death occurred _____ 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 white 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) July 4 1919

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>11</u>	<u>5</u>	<u>28</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid
(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) Vandalia Mo.

PARENTS

10. NAME OF FATHER Chas Harrelson

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

12. MAIDEN NAME OF MOTHER Thoune James

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

14.

INFORMANT Mrs Ray Gordon
(Address) 12 Sterling Ave

FILED 1931

REGISTRAR Max C. Harker

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-2-1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 30th, 1930 to Jan 2, 1931 that I last saw him alive on Jan 2, 1931, and that death occurred, on the date stated above at 2:10 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tubercular meningitis
(duration) yrs. 3 1/2 mos. 13 ds.

CONTRIBUTORY (SECONDARY) Tuberculosis Thorax
(duration) 6 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? Yes DATE OF OPERATION 1930

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Chest X-ray

(Signed) O. J. Farmer M. D.

1-3, 1931 (Address) Waltham Bldg

*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

New Bethlehem Jan 3 1931

20. UNDERTAKER

ADDRESS

Thos H. Biedermeier 1936 St Louis Mo.

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.

