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

Do not use this space.

20169

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 6412

Township ..... Primary Registration District No. 1003 Registered No. 6412

City St. Louis, Mo (No. St. Louis Mat. Hosp. St. ..... Ward)

2. FULL NAME Infant Harris

(a) Residence. No. 2812 Adams St., NW 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-17-31

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, 7 hrs. 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work nil
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Edward Harris
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Senatobia Miss
12. MAIDEN NAME OF MOTHER Carrie McCoin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Millington, Tenn

14. INFORMANT E. Edw. Harris
(Address) 2812 Adams St.

15. FILED JUN 9 1931 Max C. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 1931

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 7 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intra Uterine Asphyxia
160B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Version & Breech Extraction
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 160 B
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) [signature] M. D
, 19 (Address) St. L. Mat. Hospt

*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: Washington University
DATE OF BURIAL: JUN 9 1931

20. UNDERTAKER: Dept. Pathology
ADDRESS

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.