

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

39174
Do not use this space.

1. PLACE OF DEATH **Homer G Phillips Hospital** 791
(a) County Registration District No.
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **2601** **N Whittier** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred **43** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **10161**

2. PRINT FULL NAME **George Harris**
(a) Residence, No. **4124 Finney** St. **11**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M	4. COLOR OR RACE C	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) Sept. 8, 1887				
7. AGE YEARS 60	MONTHS 1	DAYS 18	If LESS than 1 day, hrs. or min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer			
	9. Industry or business in which work was done, as saw mill, bank, etc. unemployed			
	10. Date deceased last worked at this occupation (month and year) unavailable			
	11. Total time (years) spent in this occupation			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois				
FATHER	13. NAME Louis Harris			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky			
MOTHER	15. MAIDEN NAME Martha Long			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky			
17. INFORMANT (ADDRESS) Evelyn Sullivan 2601 N Whittier				
18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE Nov. 2 19 37				
19. FUNERAL DIRECTOR (ADDRESS) Chas. G. Batts 4107 Finney Avenue				
20. NOV 2 1937 19 J. P. Bredeck Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct. 26** 19 **37**
22. I HEREBY CERTIFY, That I attended deceased from **Oct. 11** 19**37** to **Oct. 26** 19**37**
I last saw him alive on **Oct. 26** 19**37**. Death is said to have occurred on the date stated above, at **6:55** m. **p.m.**
The principal cause of death and related causes of importance were as follows:

Cerebral arteriosclerosis

Date of onset **10/11/37**

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? **clinical**. Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify (Signed) **C. F. Lewis**, M. D.
(Address) **2601 N Whittier**

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

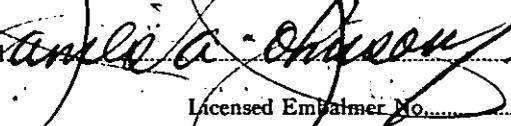
thereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed



Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)