33C

MARGIN RESERVED FOR BINDING

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.

APR 12 1939

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

791
1003

9253
Do not use this space.

3018

1. PLACE OF DEATH

(a) County St Louis City 2 Registration District No.
(b) Township Primary Registration District No. Registered No.
(c) City St Louis (d) Street No. 4394 A St Louis 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
625

2. PRINT FULL NAME Fortus Harrison (Col)

(a) Residence, No. 4394 A St Louis 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: Male
4. COLOR OR RACE: Col
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Nil

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 2/28/39

7. AGE: YEARS | MONTHS: 8 Gestation | DAYS | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Nil
9. Industry or business in which work was done, as saw mill, bank, etc.: —
10. Date deceased last worked at this occupation (month and year): —
11. Total time (years) spent in this occupation: —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St Louis Mo

FATHER
13. NAME: Ira Harrison
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St Louis Mo

MOTHER
15. MAIDEN NAME: Claudine West
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St Louis Mo

17. INFORMANT (ADDRESS): Ira Harrison 4394 A St Louis

18. BURIAL, CREMATION, OR REMOVAL: Holy Sepulchre PLACE, DATE 3/15 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Mc Cormick Bros 2590 Gravois

20. FILED MAR 31 1939 J. K. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

No attending Physician

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 2/28, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw him alive on 3-0, 19..... Death is said to have occurred on the date stated above, at 6 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Spontaneous	
Abortion	
Still Born	

Other contributory causes of importance: (Cause Unknown)

Name of operation: — Date of: No
What test confirmed diagnosis? Was there an autopsy?

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? No
If so, specify
(Signed) Joseph W. Queen, M.D.
(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.)

If this body is not embalmed, above space should be left blank.