

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

16875  
Do not use this space.

REC'D JUN 12 1939

**1. PLACE OF DEATH**

(a) County.....  
 (b) Township.....  
 or  
 City..... St. Louis (d) Street No. en route City Hosp #1 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.

**2. PRINT FULL NAME**

(a) Residence, No. 628 GOLDSON B HARRIS St. WR Philadelphia Pa  
 (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 white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wife  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1 1884  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. about 55 8 2 37  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Inspector U.S. Government  
 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

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-10-1939  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
Potassium Cyanide  
Poisoning, self administered  
in a drug store at  
No. 212 1/2 N. May 10-1939  
at about 6:50 P.M.  
 Other contributory causes of importance:  
 Name of operation Suicide Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Suicide Date of injury 5/10/39  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. 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 M. Ryan  
 (Address) Deputy Coroner

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown Phila Pa  
 FATHER 13. NAME Kepp T. Harris  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bridgeton N.J.  
 MOTHER 15. MAIDEN NAME Elizabeth Slagter  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bridgeton N.J.  
 17. INFORMANT (ADDRESS) Kepp T. Harris  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Philadelphia DATE 5/12/39  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kepp Bros L.I.C. Co.  
3029 Lafayette St. Prof  
J. Bredeck  
 20. FILED MAY 12 1939 Local Registrar.

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.

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**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:.....

*Francis J. Jones*

Licensed Embalmer No. ....

*2245*

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.**