DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37201

Registration District No. 784 Primary Registration District No. 11 Registrar's No. 1782

1. PLACE OF DEATH: (1939 NOV 9 1939)
(a) County St. Louis
(b) City or town Richmond Heights,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Clayton, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 120 Linden Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME Dr. Rufus Chas. Harris
8. (b) If veteran, name war
8. (c) Social Security No.

4. Sex Male
5. Color or Race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Gertrude Harris
6. (c) Age of husband or wife if alive years
7. Birth date of deceased January (Month) 18, (Day) 1876. (Year)

8. AGE: Years 62 Months 8 Days 20 If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Dr Medicine
11. Industry or business

MOTHER
12. Name Frederick Harris
13. Birthplace Europe (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Bertha Greengard
15. Birthplace Europe (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gertrude Harris
(b) Address 120 Linden Ave. Clayton, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/39 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cemetery
18. (a) Signature of funeral director Louis A. Bopp
(b) Address 131 W. Argonne Dr. Kirkwood
19. (a) OCT 10 1939 (Date received local registrar) C. R. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10/10/39 day
year hour 11 minute 30 A. M.
21. I hereby certify that I attended the deceased from June 1st 1939, 19..., to ..., 19...;
that I last saw h... alive on 10/10/39. 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis. Obstructive jaundice.	
Due to 4 6 ! "	
Due to	
Other conditions (Include pregnancy within 3 months of death) Carcinoma of head of pancreas.	
Major findings: Of operations Carcinoma of head of pancreas.	PHYSICIAN
Of autopsy ✓	Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work (e) Means of injury

23. Signature Warren G. Manton (M. D. or other)
Address 607 - N - Grand Date signed 10/10/39.

(Licensed Embalmer's Statement on Reverse Side)

WHITE PENCIL—USE UNFADING BLACK INK—MAKE 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.
P 1 x19511

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

Louis H Bopp, Registered Apprentice No.

working under my personal supervision.

Signed Louis H Bopp

Licensed Embalmer No. 921

P. O. Address Kirkwood

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

37201
Do not use this space.

1. PLACE OF DEATH
(a) County St Louis — Registration District No. 784
(b) Township — Primary Registration District No. 111 — Registered No. 1782
(c) City Richmond Hts (d) Street No. ____ 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 Dr Rufus Chas. Harris
(a) Residence, No. ____ St. ☐
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 18-1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	63	8	22	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ____ DATE ____, 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 10-20, 1939 T. R. Meyer D.D.P.H. *Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-10, 1939

22. I HEREBY CERTIFY, That I attended deceased from ____, 19.... to ____, 19....
I last saw h.... 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:

	Date of onset
Other contributory causes of importance:	

Name of operation ____ Date of ____
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? ____
If so, specify ____
(Signed) Herbert G. Manlove, M. D.
(Address) 607 N Grand

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.