

3-40,  
-39,  
23199

Registration District No. 284

Primary Registration District No. 101

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day 11 hrs. 15 min.  
In this community life  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town Kirkwood  
(If outside city or town limits, write "RURAL")  
Post Office No. Box 401  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Harris, Baby Boy 620

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. NONE

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 7-27-40  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>1</u>	<u>11 hr. 15 min.</u>

9. Birthplace Clayton Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation nil.

11. Industry or business \_\_\_\_\_

12. Name Earl Harris

13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Eleanor Johnston

15. Birthplace Unknown Ky.  
(City, town, or county) (State or foreign country)

16. (a) Informant St. Louis County Hospital  
(b) Address Clayton, Mo.

17. (a) cremation (b) Date thereof 8-5-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Crematory

18. (a) Signature of funeral director St. Louis County Hospital

(b) Address St. Louis, Mo.

19. (a) AUG 5-1940 (b) J.R. Meyer M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. 7 day 28  
year 1940 hour 10 minutes 00 P.M.

21. I hereby certify that I attended the deceased from 7-27-40  
\_\_\_\_\_, 19\_\_\_\_, to 7-28-40, 19\_\_\_\_;

that I last saw him alive on 7-28-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Intercranial Hemorrhage Duration 11 1/2 hrs

Due to Birth Injury

Due to 1/60 hr

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature James Boyd M.D. (M. D. or other) \_\_\_\_\_

Address St. Louis Co. Hosp. Date signed 8/7/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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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.....

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, fact should be so stated above.**