

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 3135^a Sheridan
(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

8. (a) PRINT FULL NAME Irene Smith Harris

8. (b) If veteran, name war _____

8. (c) Social Security No. None

4. Sex Female 5. Color or race col

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

6. (b) Name of husband or wife Russel Harris

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased Oct 10 1906
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>33</u>	<u>10</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Landress

11. Industry or business _____

MOTHER FATHER

12. Name Isaac J. Pl

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

14. Maiden name Irene Smith

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

16. (a) Informant's own signature Russel Harris

(b) Address 3135 Sheridan Ave

17. (a) _____ (b) Date thereof Aug 6 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Lopp

18. (a) Signature of funeral director A. H. Walton

(b) Address 2707 St. Louis

19. (a) SEP 6 1940 (b) J. P. Brodeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")

(d) Street No. 3135^a Sheridan Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3
year 40 hour 9:45 AM minutes _____ M.

21. I hereby certify that I attended the deceased from 7-18
1940, to 9-3 1940
that I last saw her alive on 9-3 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Hypertensive Heart

Due to Disease

Due to _____

Other conditions (include pregnancy within 3 months of death) 930

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) (a) Means of injury _____

23. Signature Robert M. Scott (M.D. or other) _____

Address 2839^a Madison Date signed 9-5-40

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.

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Robert H. Powell

Licensed Embalmer No. *3402*

P. O. Address *3100 Franklin*

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.