

JAN 9 1942

Registration District No. 780

Primary Registration District No. 300

Registrar's No. 2644

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Koch

(c) Name of hospital or institution: Robert O Koch Hospital
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution 304 days
(Specify whether years, months or days)

In this community 4 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County St Louis

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

(d) Street No. 5056 St Louis Ave
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME KENNETH M. HARRIS

(b) If veteran, name war NONE

(c) Social Security No. 545-01-9123

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26 year 1941 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from Feb 25, 1941 to Dec 26, 1941 that I last saw h. in alive on Dec 26, 1941 and that death occurred on the date and hour stated above.

4. Sex male race white

5. Color or race white

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

(b) Name of husband or wife _____

(c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 8 1915
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis Duration 1 1/2 yrs

Due to _____

Due to _____

Other conditions Intestinal Tuberculosis
(Include pregnancy within 3 months of death), _____

8. AGE:	Years	Months	Days	If less than one day
	<u>26</u>	<u>3</u>	<u>18</u>	hr. _____ min. _____

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

10. Usual occupation Radio Service Man

11. Industry or business _____

MOTHER FATHER { 12. Name August Clarence Harris

13. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mydia Mutert

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

Major findings: _____

Of operations _____

Of autopsy Pulmonary, Intestinal Tuberculosis

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital Record

(b) Address Robert Koch Hospital

17. (a) Burial (b) Date thereof 12/29/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

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? _____

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) DEC 27 1941 (b) E. J. McSherran
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Frank Cohen (M. D. or other) MD

Address Robert Koch Hosp Date signed Dec 27/41

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

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.....

Albert G. Hoffer

..... Licensed Embalmer No. 2971

..... 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.