

No. 1
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NEW JUL 29 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25274
Registrar's No. 1595

Registration District No. 787 Primary Registration District No. 101

96
322
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(c) Name of hospital or institution St. Louis County Hospital
(d) Length of stay: In hospital or institution 3 days
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Wellston
(d) Street No. 6230 Wells Ave
(e) Citizen of foreign country? no
If yes, name country

3. (a) PRINT FULL NAME Sadie Harris
3. (b) If veteran, name war unknown
3. (c) Social Security No. unknown

4. Sex female / race white
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Albert Harris
6. (c) Age of husband or wife it alive ? years
7. Birth date of deceased Oct. 18 1867

8. AGE: Years 74 Months 9 Days 7
If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER
12. Name Unknown Unknown
13. Birthplace Unknown Unknown
14. Maiden name unknown unknown
15. Birthplace unknown unknown

16. (a) Informant Albert C. Harris

(b) Address 6230 Wells Ave

17. (a) Burial (b) Date thereof July 28, 1942
(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Ave

19. JUL 27 1942 (Date received local registrar)
(b) W. M. Sarrano (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1942 hour 10 minute 40 p.m.
21. I hereby certify that I attended the deceased from 7-22-42
19 to 7-25-42 19
that I last saw h.er alive on 7-25-42
and that death occurred on the date and hour stated above.

Immediate cause of death: Respiratory Failure
Due to: Bronchopneumonia (Lobus 7)
Duration: 2 days
4 days

Other conditions: (Include pregnancy within 3 months of death)
Major findings: 107
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?
(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 John J. Matthey (M.D. or other)
Address St. Louis County Pop. Date signed 7/27/42

275
29/42

301 371002

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.

10. Usual occupation..... Housewife

11. Industry or business.....

MOTHER { 12. Name..... Unknown

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

MOTHER { 14. Maiden name..... Unknown

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

16. (a) Informant..... Albert C. Harris

(b) Address..... 6230 Wells Avenue.

17. (a) Burial..... (b) Date thereof. July 28, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Lake Charles Cemetery

18. (a) Signature of funeral director..... Shepard Funeral Home

(b) Address..... 1167 Hamilton Avenue.

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

Other conditions.....
(Include pregnancy within 3 months of death)25279Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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..... (M. D. or other).....

Address..... Date signed.....

(Licensed Embalmer's Statement on Reverse Side)

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.....

J. W. Wilkins

Licensed Embalmer No..... *3575*

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.