

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

26277

FILED AUG 25 1944

Registration District No. 318Primary Registration District No. 1003Registrar's No. 6825

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:
Park Lane 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)

3. (a) PRINT FULL NAME Charles Grant Harris3. (b) If veteran, name war None 3. (c) Social Security No. None4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Hazel K. Harris 6. (c) Age of husband or wife if alive 59 years7. Birth date of deceased September 1868
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
75 11 2 _____ hr. _____ min.9. Birthplace Carrier Mills Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Physician

11. Industry or business _____

12. Name Unknown13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. C.G. Harris(b) Address Festus, Mo.17. (a) Burial (b) Date thereof 8-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Festus, Missouri(a) Signature of funeral director Albert H. Hoppe(b) Address 4700 Washington Blvd.19. (a) AUG 4 1944 (b) J. F. Bradeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
 (c) City or town Festus
 (If outside city or town limits, write "RURAL", _____)
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4
year 1944 hour 8.03 minute P.M.21. I hereby certify that I attended the deceased from August 1, 1944, to August 31, 1944,
that I last saw him alive on AUG 3, 1944;
and that death occurred on the date and hour stated above.
Immediate cause of death Gastric Carcinoma
General MetastasisDuration
6 mos.Due to Arteriosclerotic Myocarditis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: May 1944
Of operations _____Of autopsy None

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.22. If death was due to external causes, fill in the following: None

(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) Means of injury _____

23. Signature Edwin J. Schisler, M.D. (M. D. or other) F.A.C.P.
Address 945 Missouri Bldg.(Licensed Embalmer's Statement on Reverse Side) St. Louis 3, Mo.

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

MOTHER FATHER

Embalmer's Certificate
State of Michigan
No. 3398
John Agnoski

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..... *John Agnoski*
Licensed Embalmer No. *3398*
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.