S. No. 2
M—5-42
. 5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 26 1945

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10625

Primary Registration District No. 6076

Registrar's No. 623

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 8950 Manchester Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: St. Louis
(c) City or town: (If outside city or town limits, write "RURAL")
(d) Street No.: 5738 Enright (If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ellen Harris
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Female
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Thomas
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: August (Month) 1 (Day) 1874 (Year)
8. AGE: Years 70 Months 7 Days 4 If less than one day hr. min.
9. Birthplace: (City, town, or county) Ireland (State or foreign country)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: John Harris
13. Birthplace: (City, town, or county) Ireland (State or foreign country)
MOTHER 14. Maiden name: Katherine Hedley
15. Birthplace: (City, town, or county) Ireland (State or foreign country)
16. (a) Informant: Henrietta Harris
(b) Address: 5738 Enright
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cem.
18. (a) Signature of funeral director: Chas. F. Stuart
(b) Address: 1225 Union Blvd.
19. (a) MAR 8 1945 (Date received local registrar) (b) E. G. McGAVRAN M.D., M.P.H. (Registrar) (c) 2 P.M. January 40

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5 year 1945 hour 4:15 minute P. M.
21. I hereby certify that I attended the deceased from 2-29, 1945 to 3/6, 1945 that I last saw her alive on 3/4, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute cardiac dilatation	1 day
Due to: Myocarditis chr.	2 yrs.
Due to:	
Other conditions: Senile dementia (Include pregnancy within 3 months of death)	3 yrs

Major findings:
Of operations: X
Of autopsy: G.H.

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

23. Signature: R. H. Leslie (M. D. or other) M.D.
Address: Kirkwood, Mo. Date signed 3/7/45

(Licensed Embalmer's Statement on Reverse Side)

X33
8/X5

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 G. W. Wilkinson

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.