

FILED AUG 11 1945

Primary Registration District No. 6087

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

1. PLACE OF DEATH: ST. Louis

(a) County Wash. Mo

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

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

(d) Length of stay: In hospital or institution 30 45 day
(Specify whether)

In this community 35 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wash.

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3840 Star Ave 9
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME HARRIS, Herbert

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex U O

5. Color or race Wh

6. (a) Single, widowed, married, divorced U 1

6. (b) Name of husband or wife Marie Amburat

6. (c) Age of husband or wife if alive _____ years
(Day) (Year)

7. Birth date of deceased July 1885
(Month) (Day) (Year)

8. AGE: Years 60 Months - Days 23
If less than one day hr. _____ min. _____

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

10. Usual occupation Teleman

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Harris

13. Birthplace Paducah Ky
(City, town, or county) (State or foreign country)

14. Maiden name Georgia Joffries

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

16. (a) Informant Robert Wood Hospital records

(b) Address _____

17. (a) Burial (b) Date thereof 8/6/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

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

(b) Address 2161 East Fair Ave

19. (a) 8-6-45 (b) E. J. McFarland
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3
year 1945 hour 8 PM minute - P. M.

21. I hereby certify that I attended the deceased from 12-23
1939 to 8-2 1945
that I last saw him alive on 8-3 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to 1361

Due to _____

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

Duration 12 5 years

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature E. J. McFarland (M. D. or other) _____
Ed. J. McFarland Date signed 8/11/45

AUG 23 1945

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 William S. Buehler

Licensed Embalmer No. 2110

P. O. Address St. Louis, Mo.

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.