

FILED NOV 10 1945
318

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **Saint Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 mos 6 days**
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2622 Stoddard**
(If rural, give location) **9**
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME ANNETTE HARRIS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** \$ 5. Color or race **Cauc** 6. (a) Single, widowed, married, divorced **Widow 0**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Jan 29th 1945**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 29 hr. min.

9. Birthplace **St Louis** **MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Baby**

11. Industry or business _____

12. Name **Island Harris**

13. Birthplace **West Point** **Miss 1**
(City, town, or county) (State or foreign country)

14. Maiden name **Jessie Salvant**

15. Birthplace **St Louis** **MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Island Harris**

(b) Address **2622 Stoddard St**

17. (a) **Burial** (b) Date thereof **10-29-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Father Duckson**

18. (a) Signature of funeral director **J. F. Bredeek**

(b) Address **3133 Bell Ave**

19. (a) **OCT 29 1945** (b) **J. F. Bredeek**
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **28**
year **1945** hour **2** minute **20** P. M.

21. I hereby certify that I attended the deceased from **1-22**
1945 to **Oct. 28**, **1945**;
that I last saw her alive on **Oct. 28**, **1945**;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myelomeningocele Spinal Bifida

Due to _____
Due to _____

Other conditions **Meningitis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **No**

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 **C. Kingsohn** (M. D. or other)
Address **2601 N. White** Date signed **10/29/45**

Duration **Unk**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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17
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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 *not embalmed*
J. H. Randle.....

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.