

FILED OCT 31 1945

Registration District No. _____

Primary Registration District No. 1003

1. PLACE OF DEATH

(a) County ST Louis - Mo.
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4429 Kemaley Ave #3
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town ST Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4318 Maffitt (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ISREAL HARRIS

3. (b) If veteran, name war No 3. (c) Social Security No. 42710-4005

4. Sex M 2 5. Color or race COL 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife No 6. (c) Age of husband or wife if alive _____ years (Day) _____ (Year) _____

7. Birth date of deceased APRIL 7 1919
(Month) (Day) (Year)

8. AGE: 26 Years Months 5 Days 26 If less than one day hr. _____ min. _____

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

10. Usual occupation LABOR

11. Industry or business _____

12. Name ISREAL BOYKIN

13. Birthplace MISS (City, town, or county) _____ (State or foreign country)

14. Maiden name BERTHA HARRIS

15. Birthplace MISS (City, town, or county) _____ (State or foreign country)

16. (a) Informant Ms BERTHA HARRIS

(b) Address 4318 MAFFITT

17. (a) BURIAL (b) Date thereof Oct 8 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREEN WOOD

18. (a) Signature of funeral director Herman Smith

(b) Address 4247 N. Republic Ave

19. (a) OCT 8 1945 (Date received local registrar) J. F. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day Oct year 1945 hour 10 minute 45 P. M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhage secondary to stab wound of heart inflicted with knife in the yard of his house 2609 N. Taylor Ave. about 2:00 P.M. around 10:40 P.M. Oct. 3, 1945

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

Major findings: _____ Of operations: _____

Of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Homicide

(b) Date of occurrence Oct 3 1945

(c) Where did injury occur? at home (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home (Specify type of place) _____ While at work? _____ Means of injury _____

23. Signature Robert Henry (M. D. or other) _____

Address St Louis Date signed 10/8/45

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

MOTHER FATHER

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 *Lawrence C. Dawson*

Licensed Embalmer No. *4341*

P. O. Address *4431 Garfield*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 1100Registration District No. 318Primary Registration District No. 1003Registrar's No. 8679

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:

(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 NAMEIsrael Harris

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

4. Sex..... m 5. Color or race..... B
 6. (a) Single, widowed, married, divorced..... S

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

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

8. AGE: Years Months Days If less than one day
26 5 26 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name.....
 13. Birthplace.....
 (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace.....
 (City, town, or county) (State or foreign country)

16. (a) Informant.....
 (b) Address.....
 17. (a) (Burial, cremation, or removal) (b) Date thereof.....
 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) NOV 13 1945
 (Date received local registrar)

I. F. Bredenk
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town.....
 (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.....
 year..... 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....;
 that I last saw him..... alive on....., 19.....;
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)Major 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?
 While at work?..... (Specify type of place)
 (e) Means of injury.....

23. Signature..... (M. D. or other)

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

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

MOTHER FATHER

SUPPLEMENTARY

31942