S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1945

State File No. 35364

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10519

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: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 days (Specify whether
In this community 25 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 2739 Delmar 21
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sylvester Harris

3. (b) If veteran, name war none

3. (c) Social Security No. 487-18-4117

4. Sex male 2

5. Color or race col.

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

6. (b) Name of husband or wife Cora Harris

6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased Aug. 25, 1896
(Month) (Day) (Year)

8. AGE: Years 49 Months 3 Days 6 If less than one day hr. min.

9. Birthplace Oklahoma 1
(City, town, or county) (State or foreign country)

10. Usual occupation Houseman

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Cora Harris
(b) Address 2739 Delmar

17. (a) Burial (b) Date thereof 12-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Dale Cem

18. (a) Signature of funeral director Allen Dailes
(b) Address 3506 Franklin Ave

19. (a) DEC 4 1945 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1
year 1945 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from 11-13-45, 19__, to 12-1-45, 19__;
that I last saw him alive on 12-1, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Bronchopneumonia	Unk
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

107

Major findings:
Of operations
Of autopsy Yes

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 Dee Brown (M. D. or other)
Address Heath Whittier Date signed 12/3

(Licensed Embalmer's Statement on Reverse Side)

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 James J. O'Meara

Licensed Embalmer No. 3522

P. O. Address 350 Franklin Ave

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. Phone - Fr. 4200