

FILED DEC 31 1946

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 3566

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch, Mo.
(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 366 DAYS
In this community 366 DAYS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 1229 N 19th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HARRISON, DAVE

3. (b) If veteran, ? name war _____
3. (c) Social Security No. NONE

4. Sex Male 5. Color or race NEGRO
6. (a) Single, widowed, married, divorced WIDOWER
6. (b) Name of husband or wife GEORGIA HARRISON
6. (c) Age of husband or wife if alive DEAD years
7. Birth date of deceased 11 26 64
(Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 16
If less than one day _____ hr. _____ min.

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

10. Usual occupation Nil

11. Industry or business _____

12. Name CHARLES HARRISON

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

14. Maiden name ANNIE GAW

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

16. (a) Informant HOSP. RECORDS

(b) Address KOCH HOSP. MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-46
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (e) Signature of funeral director W.C. Wade

(b) Address 4203 Johnson Ave

19. (a) 12-23-46 (Date received from) registrar (b) Ruth Golden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 12
year 46 hour 1 minute 10 A.M.

21. I hereby certify that I attended the deceased from 11 12 46 to 12-12-46
that I last saw him alive on 12-12-46
and that death occurred on the date and hour stated above.

Immediate cause of death PUL. TUBERCULOSIS
Duration ABOUT 2 YEARS

Due to _____
Due to 132

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 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? _____

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

23. Signature Bernard Friedman (M. D. or other) MO.
Address KOCH HOSP, KOCH, MO. signed 12-13-46

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.....

..... Licensed Embalmer No.....

..... P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.