

No. 2
2-43
1-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43657**

FILED JAN 23 1947

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **11358**

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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **7 Hrs., 20 Mins.**
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____ **2-1-17**

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

(d) Street No. **1316 Hogan**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Josephine Harris**

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

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased: **12** **22** **46**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **22**
year **1946** hour **2:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **7:10 A. M.**
12 - 22 **1946** to **2:30 P. M. 12-22, 46**

that I last saw her alive on **12 - 22**, 19 **46**
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
			7 hr. 20 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name **Dempsy Harris**

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

14. Maiden name **Bessie Lee White**

15. Birthplace **Palestine Arkansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Euther M. Sherard R.R.**
(b) Address **2601 N. Whittier Street**

17. (a) **Burial** (b) Date thereof **1-3-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **V. B. Hudson**
(b) Address **City Health Dept**

19. (a) **1-2-47** (b) **J. F. Budeck**
(Date received local registrar) (Registrar's signature)

Immediate cause of death **Prematurity**

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 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 **0**

23. Signature **William D. Fisher** (M. D.)
Address **2601 N. Whittier** Date signed **1-14-47**

(Licensed Embalmer's Statement on Reverse Side)

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

42465

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 with the above constitutes grounds for revocation of license.)

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