

No. 2
-1/47
-17-39

FILED MAY 29 1947
318
Registration District No.

Primary Registration District No. **1003**

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

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 **Christian Hospital**
(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 NAME **BEN HARRIS**

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Bertha Kibsch Harris**

6. (c) Age of husband or wife if alive **47** years

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

8. AGE:

Years	Months	Days	If less than one day
About 55			hr. min.

9. Birthplace: **London England**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business **Jewelry**

12. Name **Unknown**

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

14. Maiden name **Unknown**

15. Birthplace: **England**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Bertha K. Harris**

(b) Address **5895 Minerva Avenue**

17. (a) Burial (b) Date thereof **5-21-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chesed Shel Emeth Cem.**

18. (a) Signature of funeral director *Wm. J. ...*

(b) Address **5216 Delmar Blvd.**

19. (a) MAY 20 1947 (b) *J. F. ...*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **003**

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

(d) Street No. **5895 Minerva Avenue**
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19**
year **1947** hour **1** minute **35** P.M.

21. I hereby certify that I attended the deceased from **May 12** 19**47** to **May 17** 19**47**
that I last saw **him** alive on **May 17** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis** **1 day**

Due to **Arteriosclerosis Cerebral** ?

Due to **61** ?

Other conditions **Diabetes mellitus** ?
(include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Of operations.....

Of autopsy **Cerebral Thrombosis**
Pulmonary edema

Underline the cause of 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 **(1)**

23. Signature *John J. Wawel* (M. D. or other) **A. D.**

Address **Paul Brown Bldg** Date signed **May 20 47**

KS JUN 16 1959

[Handwritten mark]

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

John Ketter
.....
Licensed Embalmer No. *3880*
.....
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.