

National Office of Vital Statistics
FILED AUG 12 1948

Registration District No. 318

Primary Registration District No.

1003

Registrar's No.

6846

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:.....**MO. BAPTIST Hosp**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....**2 WEEK**
 (Specify whether
 In this community.....**2 WEEK**
 years, months or days)

3. (a) PRINT
FULL NAME**JAMES HARRIS**3. (b) If veteran,
name war.....**NONE**3. (c) Social Security No.
NONE

4. Sex.....**MALE** 5. Color or race.....**WHITE**
 6. (a) Single, widowed, married, divorced.....**SINGLE**
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased.....**JAN. 13 1941**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 6 29 hr. min.

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

10. Usual occupation.....**CHILD**

11. Industry or business

12. Name.....**JOHN HARRIS**
 13. Birthplace.....**St. Louis**
 (City, town, or county) (State or foreign country)
 14. Maiden name.....**ROSE BORROWS**
 15. Birthplace.....**St. Louis**
 (City, town, or county) (State or foreign country)

16. (a) Informant.....**John Harris**
 (b) Address.....**815 A McLARAN AVE**

17. (a) **BURIAL** (b) Date thereof.....**AUG. 5-1948**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....**FRIENDS CEM.**

18. (a) Signature of funeral director.....**Friedrich P. Jones**
 (b) Address.....**8319 Holly Ferry Rd.**

19. (a) **AUG. 4 - 1948** (b) **J. B. Bredbeck**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State.....**MISSOURI** (b) County.....**000**
 (c) City or town.....**St. Louis** 17
 (If outside city or town limits, write "RURAL")
 (d) Street No.....**815 A McLARAN AVE.** 9
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....**August** day.....**2**
 year.....**1948** hour.....**8:30** minute.....**P.** M.

21. I hereby certify that I attended the deceased from.....**8/2/48**
 to.....**8/2/48** 19.....
 that I last saw him alive on.....**8/2/48** 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death.....

Astrocytoma of Cerebrum
 Due to.....**ASTROCYTOMA**

Due to.....
 Other conditions.....**54**
 (Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....**Same**
 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?.....

While at work?..... (Specify type of place)
 23. Signature.....**J. B. Bredbeck** (D. or other)
 Address.....**4952 Maryland** Date signed.....**8/4/48**

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.