

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 13 1948
Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 7645

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 6 days
(Specify whether)
In this community Unk
years, months or days

3: (a) PRINT FULL NAME Joseph Harris

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

4. Sex Male 5. Color or race Negro
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 Unk
(Month) (Day) (Year)

8. AGE: Years 77 Months - Days - If less than one day hr. _____ min. _____

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

10. Usual occupation Nil

11. Industry or business _____

12. Name Unk
13. Birthplace Unk Unk
(City, town, or county) (State or foreign country)
14. Maiden name Unk
15. Birthplace Unk Unk
(City, town, or county) (State or foreign country)

16. (a) Informant S Jenkins

(b) Address Med Dir's Office-Homer G Phillips
17. (a) Anatomical Board (b) Date thereof AUG 31 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.
19. (a) AUG 31 1948 (b) J. A. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ooo
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1409 N 14th St
(If rural, give location)
(e) Citizen of foreign country? 25 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6
year 1948 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from July 31, 19 48 to August 6, 19 48;
that I last saw him alive on August 6, 19 48;
and that death occurred on the date and hour stated above.

Immediate cause of death Left Lobar Pneumonia Duration Unk

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 _____

23. Signature C. L. Daniels (M. D. or other) _____

Address 2601 N Whittier Date signed 8-12-48

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.