No. 2
—5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 1 1948

Registration District No. 217

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37401

Primary Registration District No. 3045

Registrar's No. 102

1. PLACE OF DEATH:
(a) County: Missisippi
(b) City or town: Charleston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 204 S. Locust St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: ------ (Specify whether
In this community: 25 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Mississippi
(c) City or town: Charleston
(If outside city or town limits, write "RURAL")
(d) Street No.: 204 S. Locust St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: ---------

3. (a) PRINT FULL NAME: Jacob C. 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: Married
6. (b) Name of husband or wife: Delphia Harris
6. (c) Age of husband or wife if alive: 58 years
7. Birth date of deceased: August 13, 1880 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
68	3	11	hr. min.

9. Birthplace: Brookhaven, Miss. (City, town, or county) (State or foreign country)
10. Usual occupation: Grocery Store Owner
11. Industry or business: Grocery

FATHER
12. Name: Henry Harris
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mathilda Hilson
15. Birthplace: Miss. (City, town, or county) (State or foreign country)

16. (a) Informant: A. J. Harris
(b) Address: 204 S. Locust, Charleston, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Nov. 29, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Brookhaven, Miss.
18. (a) Signature of funeral director: F. D. Sparks
(b) Address: Charleston, Mo.
19. (a) 11-27-48 (Date received local registrar) Mrs. John Bondurant (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24 year 1948 hour 11:45 minute P. M.
21. I hereby certify that I attended the deceased from 7-10-, 1948 to 11-24-, 1948 that I last saw him alive on 11-24-, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Heart Disease — Duration: 5 mo
Due to:
Due to: Chronic Nephritis — 10 mo (Hist)
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: W. A. Hengel (M. D. or other)
Address: 204 S. Locust St Charleston Mo. Date signed 11-27-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1148-1586
Date Filed 11-30-48

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 Frank J. Sparks

Licensed Embalmer No. 3855

P. O. Address Cape Girardeau Mo

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.