

FILED FEB 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3184

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 2002 Registrar's No. 273

1. PLACE OF DEATH
a. COUNTY St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)
a. STATE Missouri b. COUNTY St. Louis

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City c. LENGTH OF STAY (in this place)

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City 5, Mo. 4336

d. FULL NAME OF HOSPITAL OR INSTITUTION 846 Berick Drive

d. STREET ADDRESS (If rural, give location) 846 Berick Drive

3. NAME OF DECEASED
a. (First) Thomas b. (Middle) Benjamin c. (Last) Harris, Jr.

4. DATE OF DEATH (Month) (Day) (Year)
Jan. 30, 1951

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH Oct. 27, 1942

9. AGE (In years last birthday) 8
IF UNDER 1 YEAR: Months 3, Days 5
IF UNDER 18 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Thomas Benjamin Harris

13b. MOTHER'S MAIDEN NAME Adrienne Jane Faust

14. NAME OF HUSBAND OR WIFE T

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
T. Ben Harris, 846 Berick Drive

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Amabic dysentery

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary passive congestion

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

0460

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

522

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/19/51, 19__, to 1/30/51, 19__, that I last saw the deceased alive on 1/30/51, 19__, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. O. 217533

23b. ADDRESS Forsythe Blvd.

23c. DATE SIGNED 1/31/51

24a. BURIAL CREMATION, REMOVAL (Specify) Cremation

24b. DATE 2/1/51

24c. NAME OF CEMETERY OR CREMATORY Oak Grove Chapel

24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG. 1-31-51

REGISTRAR'S SIGNATURE Herbert R. Danke MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Ambruster Mortuary, 6633 Clayton Rd.

(Licensed Embalmer's Statement on Reverse Side)

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

1026

623/149

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....



Signed.....

Student Embalmer

Licensed Embalmer No. 1994

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.

