

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23296**

FILED JUN 26 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **1607**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkwood	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis County Hosp.		d. STREET ADDRESS (If rural, give location) 324 New York St.	
3. NAME OF DECEASED a. (First) Clifford		b. (Middle) Harris Jr.	
c. (Last) Harris Jr.		4. DATE OF DEATH (Month) (Day) (Year) June 6 1953	
5. SEX Male		6. COLOR OR RACE obl.	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Feb 2 1938	
9. AGE (In years last birthday) 15		IF UNDER 1 YEAR Months 4 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No.		10b. KIND OF BUSINESS OR INDUSTRY No.	
11. BIRTHPLACE (State or foreign country) Maplewood Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Clifford Harris Sr.		13b. MOTHER'S MAIDEN NAME Gerldine Keller	
14. NAME OF HUSBAND OR WIFE None			
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. No.	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Gerldine Harris		ADDRESS 324 New York	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) epilepsy		ANTECEDENT CAUSES		hush	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (b) _____		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.		3533	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Herbert R. Domke, M.D., Local Registrar		23b. ADDRESS 651 S. Brentwood Blvd.		23c. DATE SIGNED 6-12-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 12, 53		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE John W. Hemphill		ADDRESS 408 S. Fillmore	

15/11/20

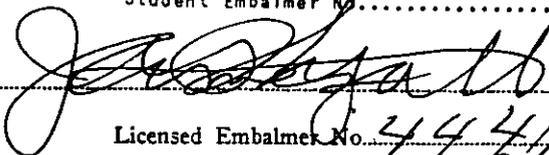
STATEMENT BY LICENSED EMBALMER

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. 4441

P. O. Address 408 S. Fell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.