

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23825**
318 PRIMARY REG. DIST. NO. **1003** Registrar's No. **5688**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 0		c. LENGTH OF STAY (in this place) 6 weeks	c. CITY OR TOWN Madison
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital		STREET ADDRESS (If rural, give location) 922 Jefferson	
3. NAME OF DECEASED (Type or Print) CURTIS HARRIS			4. DATE OF DEATH (Month) (Day) (Year) June 29, 1955
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) widowed 2	8. DATE OF BIRTH April 3, 1878
9. AGE (In years last birthday) 77		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer	10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (City and State or Foreign Country) Cape County, Missouri 0		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Harris		13b. MOTHER'S MAIDEN NAME Margarite Wilson	14. NAME OF HUSBAND OR WIFE *****
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. Unknown	17. INFORMANT'S SIGNATURE OR NAME Verdella Eaters-928 Jackson, Madison, Ill.
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) Carcinoma of Colon INTERVAL BETWEEN ONSET AND DEATH 1 Year II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?	153X
22. I hereby certify that I attended the deceased from May 15, 1955 , to June 29, 1955 , that I last saw the deceased alive on 28 , 1955, and that death occurred at 9a m., from the causes and on the date stated above.			
23a. SIGNATURE Dr. Carl Smith M.D. (Degree or title)		23b. ADDRESS 501 Woodson St. East St. Louis, Ill.	23c. DATE SIGNED July 1, 1955
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 1, 1955	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) East St. Louis, Ill.
DATE REC'D BY LOCAL REG. JUL 1 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Marshall Funeral Home-East St. Louis, Ill. ADDRESS	

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

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed *Thomas M. Habron*

Licensed Embalmer No... 4479
2205 Missouri
P. O. Address East St. Lou

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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