

0.300
0.48

FILED JAN 6 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42146

State File No.

BIRTH NO. 25900-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10623

1. PLACE OF DEATH
a. COUNTY

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

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (In this place)
c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital STREET ADDRESS 10 (If rural, give location) 3145 New Ashland 2 1/2 9/2

3. NAME OF DECEASED a. (First) Carla b. (Middle) c. (Last) Harris 4. DATE OF DEATH (Month) 12 (Day) 2 (Year) 55

5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) - 8. DATE OF BIRTH 4--24--55 9. AGE (In years last birthday) 7 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Roy Harris 13b. MOTHER'S MAIDEN NAME Lorraine Nash 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. none 17. INFORMANT'S SIGNATURE OR NAME Lorriane Harris ADDRESS 3145 New Ashland

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diarrhea INTERVAL BETWEEN ONSET AND DEATH Undt.
ANTECEDENT CAUSES
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined Cause
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Edema of Brain
Lungs - Congestion

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 571.0 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 11-30, 1955, to 12-2, 1955, that I last saw the deceased alive on 12-2, 1955, and that death occurred at 2:10a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Helen E. Nash M.D. 23b. ADDRESS 2601 N. Whittier 23c. DATE SIGNED 12-5-55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 12-5--55 24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis County Mo

DATE REC'D BY LOCAL REG. DEC 5 1955 REGISTRAR'S SIGNATURE Carl Smith MD 25. FUNERAL DIRECTOR'S SIGNATURE Hughes Funeral ADDRESS 2620 Lawton Av

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
James A. Carter

Licensed Embalmer No.....
P. O. Address.....
J. A. Carter

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.