

FILED DEC 13 1957

Registration District No. 318 Primary Registration District No. Registrar's No.

S. 300
ov. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS			c. CITY OR TOWN GILLESPIE		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET'S ADMIN HOSPITAL			d. STREET ADDRESS (If outside, give location) 400 HIGH STREET		
3. NAME OF DECEASED (Type or print) First Middle Last JAMES W HARRIS			4. DATE OF DEATH Month Day Year 12 6 57		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-2-21		9. AGE (In years last birthday) 36		10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY UNK.		11. BIRTHPLACE (City and state or country) GILLESPIE, ILL.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME ROBERT HARRIS		13b. MOTHER'S MAIDEN NAME ELLIS BOYCOTT	
14. NAME OF HUSBAND OR WIFE JENNIE HARRIS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-II		16. SOCIAL SECURITY NO. 327 16 9923	
17. INFORMANT VAH RECORDS 915 N. GRAND AVE. ST. LOUIS, MO.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) HYPERTENSION DUE TO (c) CHRONIC GLOMERULONEPHRITIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 592x		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA		20f. CITY, TOWN, OR LOCATION COUNTY STATE Gillespie Illinois	
21. I attended the deceased from 11-16-57 to 12-6-57 and last saw him alive on 12-6-57 Death occurred at 2:40 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Earl Smith M.D.			22b. ADDRESS VAH ST. LOUIS, MO.		22c. DATE SIGNED 12/6/57
23. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-7-57	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Gillespie Illinois
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington			25. DATE RECD. BY LOCAL REG. DEC 7 57		26. REGISTRAR'S SIGNATURE Earl Smith M.D.

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 *Stanley H. Dixon*
Licensed Embalmer No. *4193*
P. O. Address *St. L.*

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.