

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-034420
 STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8407**

FILED SEP 18 1961

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 1905 Carr # 507	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Sip Middle Last Harris			4. DATE OF DEATH Month 9 Day 8 Year 61		
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-19-1885	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months 1 Days 19	IF UNDER 24 HR Hours 19 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Mississippi	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Charlie Harris	13b. MOTHER'S MAIDEN NAME Mary Thomason	14. NAME OF HUSBAND OR WIFE Coreaner Harris
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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 Address Coreaner Harris 1016 4th St. Clarksdale, Miss.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Fulminating Pyelonephritis	INTERVAL BETWEEN ONSET AND DEATH Undet.
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 6000
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Prostatic Hypertrophy - Probably Myocardial Infarction	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from **8-22-61** to **9-8-61** and last saw her/him alive on **9-8-61**
 Death occurred at **8:15 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B. Prophite MD (Degree or title)	22b. ADDRESS 2601 N. Whittier	22c. DATE SIGNED 9-9-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-10-61	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Clarksdale, Mississippi
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24. FUNERAL DIRECTOR Ellis Funeral Home, Inc, 2820 Stoddard	25. DATE RECD. BY LOCAL REG. SEP 10 1961	26. REGISTRAR'S SIGNATURE Roal Smith, M.D.
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AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 Fulton E. Culkin

Licensed Embalmer No. 1198

P. O. Address Albany, N.Y.

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.