

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

3326 ~~2255~~ ³¹⁹⁴
 File No. _____
 Registered No. **824**
 St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. _____

Township _____ Primary Registration District No. _____

City St. Louis (No. 2800) Randolph St. _____ Ward)

2. FULL NAME

(a) Residence No. 2800 Randolph St. 22 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 12, 1869

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
60	10	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework
 (b) General nature of industry, business, or establishment in which employed (or employer). at home
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

10. NAME OF FATHER

Alfred Harr

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER

Harriett Oliver

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

14.

INFORMANT Ben Griffin
 (Address) 2800 Randolph St

15.

JAN 25 1935
 FILED Mar C. Walker
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/22 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Jan 20, 1930, that I last saw him alive on Jan 20, 1930, and that death occurred, on the date stated above, at 2:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bright's Disease Chronic
 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY)

Toxemia
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH at place of death

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Urines & Circulation

(Signed) G. T. Willard, M. D.

, 19 (Address) 103 1/2 W. Main & Gris Wd.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Louis Ill.

DATE OF BURIAL 1/26 1930

20. UNDERTAKER R. M. O. Green

ADDRESS 3577 Oakdale

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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