

MAY 7 1936

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

Do not use this space.

791

17920

1. PLACE OF DEATH

County Registration District No. **1003**
Township Primary Registration District No. **1003**
City **St. Louis** (No. ~~1003~~ **Route to 1003**) Registered No. **4745**
Ward

2. FULL NAME

ANNAD. Harris
(a) Residence, No. **2687 North 9th St.** Ward. **26**
(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 **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan 19th 1880**
7. AGE YEARS **56** MONTHS **3** DAYS **11** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Housewife**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**13. NAME **Sammie Campbell**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**15. MAIDEN NAME **Jane Murphy**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**17. INFORMANT **George Harris**
(ADDRESS) **2687 N. 9th St.**18. BURIAL, CREMATION, OR REMOVAL PLACE **Hellick I L L** DATE **April 30th 1936**19. UNDERTAKER **Albert H. Hoff Inc**
(ADDRESS) **427 North Cass St.**20. FILED **APR 29 1936** **J. Predeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 28th 1936**

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw h..... alive on..... Death is said

to have occurred on the date stated above, at **3:00 P.M.**

The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy Date of onset**Arterio Sclerosis**

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?.....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) **Frank Phelan**(Address) **Corcoran**

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.

