PLACE OF DEATH

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

County Wayne

Township Black River

or Village ~~Chaonia~~

or City _____ (NO. _____ St.: _____ Ward)

Registration District No. 892 File No. 7984

Primary Registration District No. 6194 Registered No. 1

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William Wilford Harshbarger

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Feb 5 (Month) 5 (Day), 1858 (Year)

AGE: 53 yrs. 11 mos. 14 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 1-02

BIRTHPLACE (City or town, State or foreign country): Wayne County Jail

PARENTS

NAME OF FATHER: William Harshbarger

BIRTHPLACE OF FATHER (City or town, State or foreign country): Viragina

MAIDEN NAME OF MOTHER: Emily Spiane

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minerva Harshbarger

(ADDRESS) Chaonia Mo

Filed Feb. 9, 1912. J. L. McGhee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 21 (Month) 14 (Day), 1912 (Year) 53

I HEREBY CERTIFY, that I attended deceased from 4 o'clock Jan 21, 1912, to 4 30 Jan 21, 1912, that I last saw him alive on Jan 21, 1912, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108 92

(Duration) ___ yrs. ___ mos. 10 ds.

Contributory (SECONDARY) _____

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) S J Chenoweth M. D.

1-22, 1912 (Address) Chaonia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Chaonia Cemetery

DATE OF BURIAL: 1-23-, 1912

UNDERTAKER: Kube Talley

ADDRESS: Chaonia Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.

MISSOURI STATE BOARD OF HEALT

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... , ... St.: ..... Ward)

[If death occurred hospital or instit give its NAME i of street and numb

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ..... , 191..... , ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , 1
(Month) (Day) (

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 19

that I last saw h.....alive on....., 19

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos.

Contributory.....
(SECONDARY)

.....(Duration).....yrs. .....mos.

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIEN RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS