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.

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

PLACE OF DEATH

County Pettis

Township Houstonia

or

Village

or

City (NO. , St.; Ward)

Registration District No. 665

Primary Registration District No. 5885

File No. 40136

Registered No. 12

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

FULL NAME Harris

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Dec (Month) 21 (Day), 1912 (Year)

AGE ___ yrs. ___ mos. ___ ds. If LESS than 1 day, 2 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) 1516 1610 1520

BIRTHPLACE (City or town, State or foreign country) Mo 1520

PARENTS

NAME OF FATHER John T Harris

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

MAIDEN NAME OF MOTHER Eula Crumpflecker

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J A Smith M D

(ADDRESS) Houstonia Mo

Filed Dec 22, 1912 C L Parkhurst REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

DATE OF DEATH Dec (Month) 21 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 21, 1912, to Dec 21, 1912, that I last saw her alive on Dec 21, 1912, and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

She died 2 hours after birth (Blue baby) Cyanosis

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

Contributory (SECONDARY) heart failure

(Duration) ___ yrs. ___ mos. 2 hours ds.

(Signed) J A Smith M. D.

Dec 21, 1912 (Address) Houstonia 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 Houstonia Cemetery

DATE OF BURIAL 12-22, 1912

UNDERTAKER F C Voigt

ADDRESS Houstonia Mo

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

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.

PLACE OF DEATH

County _____

Township _____ or

Village _____ or

City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (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 _____ (Month) _____ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS