

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

Do not use this space.

2294

1. PLACE OF DEATH  
 County St. Clair Registration District No. 765 File No. \_\_\_\_\_  
 Township Osceola Primary Registration District No. 4460 Registered No. 1  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Margaret Linney Harrison  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 4 1927

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

17. I HEREBY CERTIFY, That I attended deceased from Feb 1927 to Jan 4 1927 that I last saw h. e. alive on Jan 4 1927, and that death occurred, on the date stated above, at 7 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 2 1901

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Intestinal Tuberculosis

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
25 | 4 | 2 | \_\_\_\_\_

230  
231  
 CONTRIBUTORY (SECONDARY) Pulmonary T.B.  
 (duration) yrs. mos. da. \_\_\_\_\_  
 (duration) yrs. mos. da. \_\_\_\_\_

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Osceola  
 (STATE OR COUNTRY) Mo.

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF Oct 1927

10. NAME OF FATHER Geo. B. Linney

WAS THERE AN AUTOPSY? no

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Danville  
 (STATE OR COUNTRY) Kentucky

WHAT TEST CONFIRMED DIAGNOSIS? Krag. microscop  
 (Signed) Rich. Seegers, M. D.

12. MAIDEN NAME OF MOTHER Lulu Lewis

1/5, 1927 (Address) Osceola Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Osceola  
 (STATE OR COUNTRY) Mo.

\*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.

14. INFORMANT Mrs Geo. B. Linney  
 (Address) Osceola Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Osceola Mo DATE OF BURIAL 1-6 1927

FILED 1/3 27 1927 R. Seegers REGISTRAR

20. UNDERTAKER O. S. Hull ADDRESS Osceola

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.

28 1927

