

Do not use this space.

OCT 4 1962

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

no Dr
File No. _____
Registered No. _____
St. _____ Ward)

1. PLACE OF DEATH.....
County.....
Township.....
City.....

Registration District No. 904
Primary Registration District No. 6210

2. FULL NAME Harsh M. Mehta

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17-1840

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	88	10	22	

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)..... *H*

(c) Name of employer..... *U*

9. BIRTHPLACE (CITY OR TOWN) 19
(STATE OR COUNTRY) Mo. Jan. Co. Ark.

10. NAME OF FATHER Jack E. Powers

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

12. MAIDEN NAME OF MOTHER Harrah Mann

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

14. INFORMANT D. S. Duley
(Address) Frank City Mo

15. FILED Aug 18 1967 J.B. Nigh
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9 1927

17. I HEREBY CERTIFY, That I attended/deceased from
 , 19....., to , 19.....
 that I last saw h..... alive on , 19....., and that
 death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS: 10

(duration) yrs. mos. da.

CONTRIBUTORY
(SECONDARY)

405-B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Spain*
IF NOT AT PLACE OF DEATH: _____

11. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
 , 19 (Address)

*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	DATE OF BURIAL
Mt Vernon Cemetery	7-13 19

20. UNDERTAKER	ADDRESS
SW. Union Grand City 71	

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.

