OCT 25 1927

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

Do not use this space.
26667

1. PLACE OF DEATH
County Callaway. Registration District No. 104
Township Fulton. Primary Registration District No. 3153
City ..... (No. ....., ... St. ..... Ward)

File No. .....
Registered No. 181

2. FULL NAME Doyle Heskey Harris.

(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: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch.15th.1915

7. AGE: Years 12 | Months 5 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER Chas-A.Harris.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Va.
12. MAIDEN NAME OF MOTHER Hernie Lanie Landers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.

14. INFORMANT Chas -A-Harris,
(Address) Fulton. Mo.

15. FILED Sept 5 1927 R. M. Crews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1927, to Sept 4, 1927, that I last saw h. alive on Sept 4, 1927, and that death occurred, on the date stated above, at 4.25 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cholera Morbus
12 hr (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) K. D. Owen, M. D
, 19 (Address) Fulton 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Pioneer Cemetery. DATE OF BURIAL: Sep 5/ 1927

20. UNDERTAKER: Herndon-Taylor Furn-Co. ADDRESS: Fulton. Mo.

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.