OCT 29 1927

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

Do not use this space.

File No. 29347
Registered No. 163

1. PLACE OF DEATH

County: Vernon
Registration District No. 875
Township:
Primary Registration District No. 3039
City: Nevada (No. ..... St. ..... Ward)

2. FULL NAME Fielding C. Harris

(a) Residence. No. State Hospital #3 St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 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): Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: D. K.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): D.K. about 1854

7. AGE: about 73 Years; D. Months; 19? Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: Farming 131 071 84
(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) Saline Co. Mo.

PARENTS

10. NAME OF FATHER: Burrel Harris
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky.
12. MAIDEN NAME OF MOTHER: Nancy Tenis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

14. INFORMANT: Hospital Record.
(Address) State Hospital #3

15. FILED 10/8 1927 E. R. Kring
REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 14 1927

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1927 to Sept. 14, 1927 that I last saw h.. alive on Sept. 13, 1927 and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Nephritis Chronic
Mitral Regurgitation
Manic Depressive
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Nephritis Chronic
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? D.K.
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) F. H. Mapes, M. D.
Sept 14 1927 (Address) State Hospital #3

*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: Sedalia Mo
DATE OF BURIAL: Sept 16 1927

20. UNDERTAKER: Terry Funeral Home
ADDRESS: Nevada 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.