

JAN 23 1929

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

Do not use this space.

40437

1. PLACE OF DEATH

County Jackson Registration District No. 398 File No. _____
Township Bliss Primary Registration District No. 3019 Registered No. 420
City Independence Mo. St. _____ Ward _____

2. FULL NAME Sallie A. Harris

(a) Residence No. 302 S. Osage St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 75 yrs. 5 mos. _____ da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX woman 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 Edgar C. Harris

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 5 - 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75 5 0 0 0

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

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

10. NAME OF FATHER John Parker

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

12. MAIDEN NAME OF MOTHER Elizabeth Anne Lamm

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

14. INFORMANT E. P. Harris (Address) Wellington Canal

15. FILED Del 19 28 J. L. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4
16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 19 28

17. I HEREBY CERTIFY that I attended deceased from Nov 15, 1928, to Dec 5, 1928 that I last saw her alive on Dec 3, 1928, and that death occurred, on the date stated above, at 7:30 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dysentery - Colic - Septicemia
from infected hip.
1864
1948
56 (duration) yrs. mos. 10 da.
CONTRIBUTORY (SECONDARY) Parasitic infection
fever (duration) yrs. mos. 2 da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

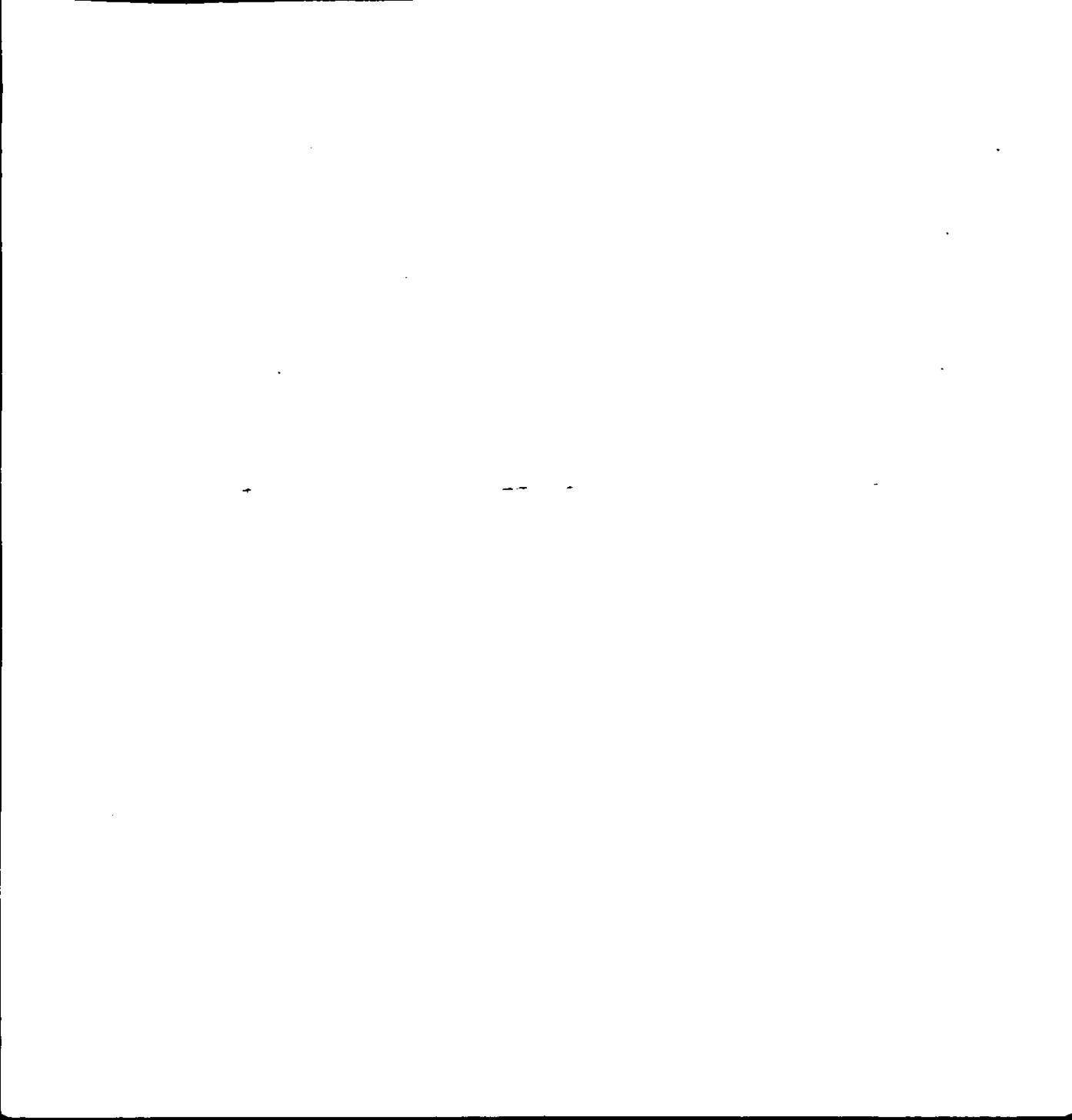
20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) E. P. Allen, M. D.
12-6-28 (Address) E. P. Allen

*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 Wood Lawn DATE OF BURIAL Dec 7 19 28

20. UNDERTAKER W. H. Mitchell ADDRESS Sid Mo



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 398 File No.
Township Ind. Primary Registration District No. 3019 Registered No. 420
City Ind. (No.) St. Ward)

2. FULL NAME

Sallie A. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 2/5-29 F. L. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 1928

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:

Streptococic Septicemic from abscessed tip of her nose which perforated structure of neck of left femur
(duration) yrs. mos. ds.

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

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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-40437