

MAY 27 1929

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

Do not use this space.

7054-a

1. PLACE OF DEATH

County... *Raymond*  
Township... *Paul*  
City... *Chillicothe* (No. .... St. .... Ward)

Registration District No. *460*  
Primary Registration District No. *5624-a*

File No. ....  
Registered No. *27*

2. FULL NAME *Ross Lee Harrison*

(a) Residence. No. .... St. .... Ward.  
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

2. 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug. 5, 1925*

7. AGE YEARS MONTHS DAY If LESS than 1 day, hrs. or min. *3 6 19*

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) *Corder* (STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Jeff Harrison*

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

12. MAIDEN NAME OF MOTHER *Marina Reise*

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

14. INFORMANT (Address) *Jeff Harrison*  
*Corder Mo*

15. FILED *4/23*, 19*29* *Jessie P. Porter* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 22 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 16* 19*29*, to *Feb 22* 19*29*. That I last saw him alive on *Feb 22* 19*29*, and that death occurred, on the date stated above, at *9:30 A. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*1929*  
*Bronchopneumonia*  
(duration) yrs. mos. *4* da.  
CONTRIBUTORY (SECONDARY)  
(duration) yrs. mos. da.

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? *Chymerin*  
(Signed) *Fredrick B. Spencer*, M. D.  
, 19 (Address) *Corder, 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 *Corder Cemetery* DATE OF BURIAL *2/24/29*

20. UNDERTAKER *Koefler & Mumershagen* ADDRESS *Higgumville Mo*

K. R.—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.

THIS IS A PERMANENT RECORD

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PARENTS

