

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

Do not use this space.

18903

1. PLACE OF DEATH

County Newtown Registration District No. 414
Township _____ Primary Registration District No. 4555
City Granby No. _____ St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Lance Lee 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-26-1890

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day	hrs.	or	min.
<u>34</u>	<u>6</u>	<u>8</u>					

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Granby
(STATE OR COUNTRY) MO

10. NAME OF FATHER Thos Watson

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

12. MAIDEN NAME OF MOTHER Elizabeth Walker

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

14. INFORMANT Robert Harris
(Address) Granby MO

15. FILED 2, 1929 W. C. Adams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4, 1929

17. HEREBY CERTIFY, That I attended deceased from about Apr 1st, 1929 to May 4, 1929 that I last saw him alive on Apr 28, 1929, and that death occurred, on the date stated above, at 3:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
T.B. about
(duration) yrs. 12 mos. da.

CONTRIBUTORY (SECONDARY) SI
(duration) yrs. mos. da.

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) W. Langley, M. D.

(Address) Granby 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 Granby Cemetery DATE OF BURIAL May 29
20. UNDERTAKER W. C. Adams ADDRESS Granby MO

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Newton Registration District No. 614 File No.
Township Granby Primary Registration District No. 425-5- Registered No.
City Granby (No. St. Ward)

2. FULL NAME

Laura Lee 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) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 26-1890

7. AGE YEARS 38 MONTHS 6 DAYS 8 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 5-6, 1929 M. F. Palmer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4 19 29

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (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

THEY ARE COMPLETE AS PREPARED

REGISTRARS SHALL NOT RECEIVE A FEE

SUPPLEMENTARY

S-18903