

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

Do not use this space.

21775

1. PLACE OF DEATH

County Jackson
Township Raytown
City Raytown (No. 1403)

Registration District No. 1403
Primary Registration District No. 4238

File No. _____
Registered No. 174
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Harrison P. R. #3 St. Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 25 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 6 23

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer) 20 yrs N. C. Kas
(c) Name of employer past 3 yrs in Raytown Mo

9. BIRTHPLACE (CITY OR TOWN) Andrain Co. Mo.
(STATE OR COUNTRY) Mexico

10. NAME OF FATHER Jno F. Harrison

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

12. MAIDEN NAME OF MOTHER Mary B. Crockett

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

14. INFORMANT Frank Kelly Harrison
(Address) Lees Summit Mo.

15. FILED 1/17 19 29 W. H. Hobbs
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 Monday
16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 19 29.

17. I HEREBY CERTIFY, That I attended deceased from Oct 1
19 28, to June 17, 19 29.
that I last saw him alive on June 17, 19 29, and that death occurred, on the date stated above, at 9:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency
9:2 A
P. 31 (duration) 8 yrs 8 mos 1 ds.
CONTRIBUTORY Chronic myocarditis
(SECONDARY) (duration) 3 yrs — mos — ds.

18. WHERE WAS DISEASE CONTRACTED? At home
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? Physical signs
(Signed) W. H. Hobbs M. D.

(Address) Raytown

*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 Mexico Mo. DATE OF BURIAL 6-19 19 29

20. UNDERTAKER Clyde Funeral Home ADDRESS 1800 Linnwood

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUL 25 1929

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