

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

Do not use this space.

142

1. PLACE OF DEATH

County Boone

Registration District No. 373

Township

Primary Registration District No. 3006

City Columbia (No. _____)

File No. _____

Registered No. 10

St. _____ Ward _____

2. FULL NAME

Mrs. Emily Harske

(a) Residence No. 401 So 6 St 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 12 1877

7. AGE YEARS MONTHS DAYS If LESS than a day, hrs. or min.
72 9 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Robert S. Robinson

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

12. MAIDEN NAME OF MOTHER Virginia Bowen

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

14. INFORMANT Robert W. Harske (Address) Chicago

15. FILED 178 1930 Malice J. Gubb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1929 to Jan 15 1930 that I last saw her alive on Jan 15 1930 and that death occurred, on the date stated above, at 10:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
131
1929
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic Tapesitis
(duration) 1 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? But Storie, M. D.
(Signed) _____
115 (Address) Columbia

*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 S. S. Harske DATE OF BURIAL 1-18 1930

20. UNDERTAKER Tom M. Harg ADDRESS Columbia

CAUTION: This form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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