

APR 28 1930

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

Do not use this space.

8357

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 201

City Springfield (No. 431)

W. Boulevard

File No. _____

Registered No. 203

St. _____ Ward) _____

2. FULL NAME

Archie Leroy Harrison

(a) Residence, No. _____ St., _____ Ward.

(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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29-1929

7. AGE	YEARS	MONTHS	DAYS	IF LESS than I day, hrs. or min.
	<u>7</u>	<u>4</u>	<u>9</u>	<u>—</u>

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Archie Harrison

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

12. MAIDEN NAME OF MOTHER Ellen Duncan

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

14. INFORMANT Archie Harrison (Address) 1130 W. Boulevard

15. FILED 3-7-30 Tom Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-6 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 3, 1930, to Mar 6, 1930, that I last saw him alive on Mar 6, 1930, and that death occurred, on the date stated above, at 3:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

157A Pneumo-pneumonia
du (duration) yrs. 3 wks. 4 ds.

CONTRIBUTORY (SECONDARY) Convulsions (duration) yrs. 2 ds.

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? (Signed) Chas A. George, M. D. (Address) Springfield, 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 Lincoln Memorial DATE OF BURIAL Mar 7 1930

20. UNDERTAKER W. Campbell ADDRESS 414 869 Wash

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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