

MAY 28 1930

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

Do not use this space.

15999

## 1. PLACE OF DEATH

County *Sullivan*Registration District No. *852*Township *Jackson*Primary Registration District No. *6124*City *Boonville* (No. ....)

File No. ....

Registered No. *18*

St. .... Ward)

## 2. FULL NAME

*Catherine Harrelson*

(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

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Widowed*

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

*Calvin Harrelson*

## 6. DATE OF BIRTH (MONTH, DAY AND YEAR)

*May 12, 1857*

## 7. AGE

*72**10**21*

If LESS than 1 day, .....hrs. or .....min.

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

*Housewife*

(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)

*Scotland County, Missouri*

## 10. NAME OF FATHER

*Hiram Washburn*

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

*New York*

## 12. MAIDEN NAME OF MOTHER

*Margaret Hogeland*

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

*New York*

## 14. INFORMANT (Address)

*Tom Harrelson  
Boonville, Mo.*

## 15. FILED 4-6, 1930

*Boonville, Mo. McClary  
REGISTRAR*

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH (MONTH, DAY AND YEAR)

*April 3 1930*

## 17.

I HEREBY CERTIFY, That I attended deceased from *April 2* 19*30* to *April 2* 19*30* that I last saw *her* alive on *April 2* 19*30*, and that death occurred, on the date stated above, at *2:30 a. m.*

## THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Chronic myocarditis  
93C  
106P*

(duration) .....yrs. ....mos. ....ds.

## CONTRIBUTORY (SECONDARY)

*Chronic Bronchitis*

(duration) .....yrs. ....mos. ....ds.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

## 18 DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY?

## WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *Henry A. Shale* M. D.1930 (Address) *Milan, 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

## DATE OF BURIAL

*Fairview Cem.**April 5 1930*

## 20. UNDERTAKER

## ADDRESS

*C. A. Schwere**Milan, Mo.*

K. 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.

