

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

Do not use this space.

**15329**

**1. PLACE OF DEATH**

County Boon Registration District No. 29  
 Township Barren Primary Registration District No. 4047  
 City Sturgeon (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Walter Jackson Harlow  
 (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 MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-24-1837

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>93</u>	<u>2</u>	<u>5</u>		

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Kentucky  
 (STATE OR COUNTRY)

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know  
 (STATE OR COUNTRY)

14. INFORMANT Mr. Ruby Harlow  
 (Address) Sturgeon, MO

15. FILED 6/2/30 1930 E. N. Gentry REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1924, to May 29 1930, that I last saw him alive on about 11 22 1930, and that death occurred, on the date stated above, at 2:00 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Gas. Debility aged agt  
1864  
1945  
162 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Broken down about 42  
below. ref. game (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

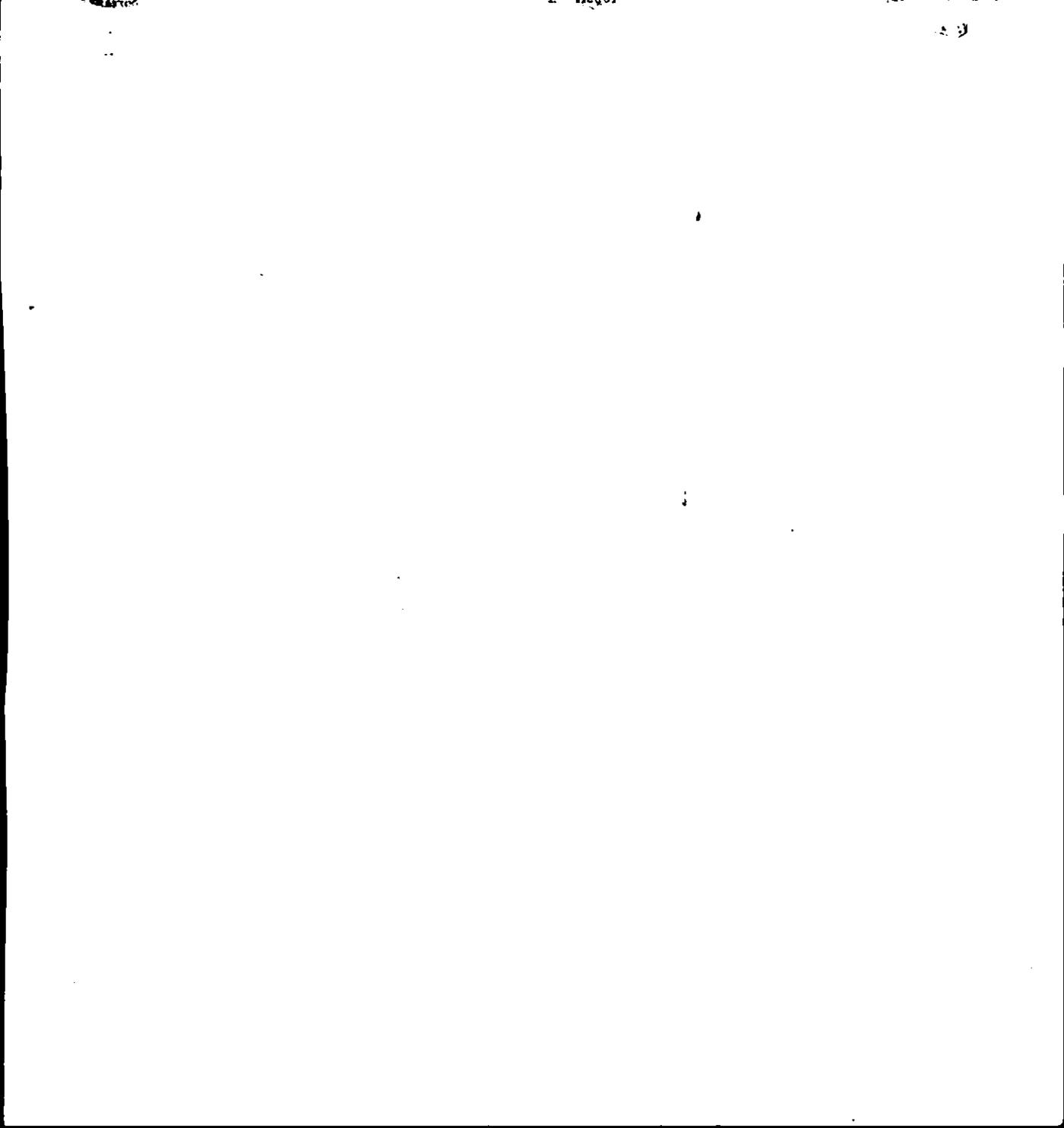
20. WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) W. A. Johnson, M. D.  
 , 19 (Address) Sturgeon 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 Public Cem, DATE OF BURIAL 5/29 1930

20. UNDERTAKER Barner Funeral Home Sturgeon, MO ADDRESS \_\_\_\_\_



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

ALL INFORMATION REQUESTED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Boone Registration District No. 49 File No. 13  
 Township Sturgeon Primary Registration District No. 4047 Registered No. \_\_\_\_\_  
 City Sturgeon (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME**

Andrew Jackson Harbor  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1930

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

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

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS 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 \_\_\_\_\_

CONTRIBUTORY Broken femur (accidental) (duration) yrs. mos. ds.  
caused by a fall and a  
fracture on old age (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

185 WAS THERE AN AUTOPSY? \_\_\_\_\_

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

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

, 19 \_\_\_\_\_ (Address)

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

\*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.

14. INFORMANT \_\_\_\_\_ (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

15. FILED 7/2/30 E. N. Lentry REGISTRAR

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Exact statement of OCCUPATION is very important.

6.10.10

10.10.10

10.10.10