

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

Do not use this space.

**1. PLACE OF DEATH**

County Miller  
Township Saline  
City..... (No.....).....

Registration District No. 561  
Primary Registration District No. 5733-

**16774**  
File No.....  
Registered No. 31  
St..... Ward.....

**2. FULL NAME**

Bessie Harrison

(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 <u>Female</u>	4. COLOR OR RACE <u>Negro</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept. 9, 1913</u>		
7. AGE	YEARS	MONTHS
	<u>16</u>	<u>8</u>
		DAY
		<u>21</u>
		IF LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

**9. BIRTHPLACE (CITY OR TOWN)**

Cooper Co. Mo.

**PARENTS**

10. NAME OF FATHER Henry Harrison  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Columbia  
(STATE OR COUNTRY) Mo  
12. MAIDEN NAME OF MOTHER Rosa McKinsie  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Monitau  
(STATE OR COUNTRY) Mo

**14.**

INFORMANT Henry Harrison  
(Address) Oldon. Mo

**15.**

FILED 5-31, 1930 Belle Haynes  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 1930  
17. I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to May 31, 1930, that I last saw her alive on May 31, 1930 and that death occurred, on the date stated above, at 6 P. m.

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

Concussion of Brain from blow on left side of Head. Dislocation of Odontoid Process.  
(duration) ..... yrs. .... mos. .... ds.

**CONTRIBUTORY (SECONDARY)**

1750 (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

7 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Evidence of External Violence

(Signed) J. H. Kamm M. D.

, 19 (Address) Columbia 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**

Monitau Cemetery 5-31 1930

**20. UNDERTAKER**

**ADDRESS**

W. A. Phillips Oldon Mo.

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.

26130



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Miller  
Township Galena  
City (No. ....) .....

Registration District No. 561  
Primary Registration District No. 0755-

File No. ....  
Registered No. 31  
St. .... Ward

**2. FULL NAME** Bessie Harrison

(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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

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

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED

5-30-30 Belle Hayes

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 19 30

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH WAS AS FOLLOWS:

Concussion of brain, from blow on left side of head homicidal

CONTRIBUTORY (SECONDARY)

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

(Signed)

, 19 (Address)

\*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

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated in FULL YEARS. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

SUPPLEMENTARY

1930

S-16774