

DEC 22 1930

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

Do not use this space.

36753

1. PLACE OF DEATH

County Macon
Township Macon
City Macon (No. _____)

Registration District No. 533
Primary Registration District No. 3027

File No. _____
Registered No. 91
St. _____ Ward _____

2. FULL NAME

Benjamin Franklin 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. 2 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or WIFE OF) Edna Harrison

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 29-1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 1 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Joe Harrison

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

12. MAIDEN NAME OF MOTHER Mary Ball

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

14. INFORMANT Mrs Edna Harrison
Macon Mo.
Address _____

15. FILED 11/30 1930 Mrs Luke Funkle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/22 1930

17. I HEREBY CERTIFY, That I attended deceased from June 1-1920, to 11-22 1930, and that I last saw him alive on 11-22 1930, and that death occurred, on the date stated above, at 10 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Uremia

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis

Nephritis (duration) 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

(Signed) A. C. Chamber, M. D.

11/24 1930 (Address) Atlanta 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

Mt. Salem Cem DATE OF BURIAL 11-24 1930

20. UNDERTAKER

Stephen Gooding ADDRESS Macon 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.

**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 Macou
Township
City 11 11 (No.) St. Ward

Registration District No. 133
Primary Registration District No. 3027

File No.
Registered No. 91

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 29 - 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min.
160 1 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
(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 1/7 31 Mrs Luke Funkler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/22 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) 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?

(Signed) M. D. , 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

WRITE PLAINLY IN UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every form must be carefully filled. AGE should be stated in full. P. H. C. No. should state CAUSE OF DEATH in plain language so that it may be properly classified. Fee for registration of OCCUPATION is very important.

REGISTRARS SHALL NOT BE RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED UNLESS IT IS COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-36753