

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

Do not use this space.

39212

PLACE OF DEATH

County Walt
Township Walt
City Mound City (No. _____ St. _____ Ward)

Registration District No. 372
Primary Registration District No. 4218

File No. _____
Registered No. 695

2. FULL NAME

Nancy J. 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7th 1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
80 10 6

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. House 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) Indy

10. NAME OF FATHER James Purge

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

12. MAIDEN NAME OF MOTHER Sarah Ann Picher

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

14. INFORMANT Frank Vest
(Address) Mound City Mo.

15. FILED 12-14-30 1930
J. O. Freney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-12-1930
17. I HEREBY CERTIFY That I attended deceased from Jan 15, 1928, to Dec 13, 1930 that I last saw her alive on Dec 12, 1930 and that death occurred, on the date stated above, at 11 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uterine Cancer
48 (duration) 7 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 46 (duration) _____ yrs. _____ mos. _____ 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 clinical
73 (Signed) H. E. Freney, M. D.
30 (Address) Mound City 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 New Liberty DATE OF BURIAL 12-14-1930

20. UNDERTAKER W. H. Crawford ADDRESS Mound City 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.

JAN 19 1931

PARENTS

