

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

Do not use this space.

1. PLACE OF DEATH

County Howard Registration District No. 378
 Township _____ Primary Registration District No. 4222
 City Fayette (No. _____) St. _____ Ward _____

File No. 21269
 Registered No. 00

2. FULL NAME

Archie Harris
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 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>male</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>1987</u>		
7. AGE YEARS <u>about 43</u>	MONTHS <u>+</u>	DAYS <u>+</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) <u>Howard Co Mo</u> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <u>Archie Harris</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Howard Co Mo</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>Tabbie Bowman</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Howard Co Mo</u> (STATE OR COUNTRY)	
14. INFORMANT <u>Robt Harris</u> (Address) <u>7 Franklin St</u>		
15. FILED <u>6-30-31</u> <u>D. O. Borham</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-29-1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 8:30 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Ruptured Aorta (Hemorrhage)
Caused from Blunt
on abdomen, Home side
175 B L.P (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (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? yes

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. A. Stawbuis M. D.
6-30-31 (Address) Coroner
Wagon 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 <u>Wt Pleasant</u>	DATE OF BURIAL <u>7-1 1931</u>
20. UNDERTAKER <u>Edman Wagon</u>	ADDRESS <u>Wagon Mo</u>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUL 25 1931

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