

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

Do not use this space.

7627

MAR 24 1934

1. PLACE OF DEATH

County Moath
Township Waller
City Parnell (No. _____) St. _____ Ward _____

Registration District No. 1084
Primary Registration District No. 6244

File No. _____
Registered No. _____

2. FULL NAME

Amanda Jane Harris
(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 (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James C. Harris

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 25, 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 11 27

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER George White

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

12. MAIDEN NAME OF MOTHER Nancy J. Lester

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

14. INFORMANT Sam Harris
(Address) Grant City, Mo.

15. FILED Feb 27 1934 Mrs. O. H. Bond
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 22 1934

17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1934, to Feb 21, 1934, that I last saw him alive on Jan 30, 1934, and that death occurred, on the date stated above, at 7:30 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis

131 (duration) unknown yrs. _____ mos. _____ ds.
CONTRIBUTORY 131 valvular heart disease
(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? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Egbert Crowson, M. D.
, 19 _____ (Address) Parnell 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 Oxford Cem. DATE OF BURIAL 2/23 1934

20. UNDERTAKER Arch C. Dimpfel ADDRESS Grant City

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.

