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

Do not use this space.

22868

1. PLACE OF DEATH
County Stoddard — Registration District No. 836 — File No. 48
Township Liberty — Primary Registration District No. 6098a — Registered No. 48
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Isem Harbough

(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.

4

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~~ Adaline Harbough

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	10	3	

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) Sumner
(STATE OR COUNTRY) Ill

PARENTS

10. NAME OF FATHER David Harbough
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pont Knox
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Anna Huffstetter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
(STATE OR COUNTRY)

14. INFORMANT Bobbie Barnes
(Address) Bernie Mo.

15. FILED 6/29 1934 Florence Allen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6 28 1934

17. I HEREBY CERTIFY, That I attended deceased from 4-16, 1932, to 6/28, 1934 that I last saw him alive on 6/26, 1934, and that death occurred, on the date stated above, at 6 45 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Auto-intoxication
82A
124E
69B
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Senility
..... (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) J. F. Riddle, M. D.
, 19 (Address) Bernie, 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: Stevenson Cemetery
DATE OF BURIAL: 6/29 1934

20. UNDERTAKER: Landess & Son
ADDRESS: Campbell, Mo

#2

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Standard

48

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Sam Harbough

Who died at _____ on June 28 - 1954

Residence: No. _____ St. _____

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W ~~Single~~, married, ~~widowed~~ or ~~divorced~~: _____

Date of birth Aug 25, 1858 Age: Years 75 Months 10 Days 3

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month 8 Year 20

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Auto intoxication

Apoplectic stroke some months ago Anemia - Hepatitis Chronic

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Florence Allen

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh M.D.

Special Agent.

Reg. Dist. No. 836

Primary Reg. Dist. No. 6098a

B.—Every item of information should be carefully supplied. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly

S-22868

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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