

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.

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

Do not use this space.

SEP 6 1934

29698

**1. PLACE OF DEATH**

County Jasper Registration District No. 408 File No. 29698  
 Township Carthage Primary Registration District No. 3020 Registered No. \_\_\_\_\_  
 City Carthage (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Lee Grace Harpman  
 (a) Residence, No. 1122 Cedar St., \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 1 yrs.  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 Child (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14<sup>th</sup> 1931

7. AGE YEARS 3 MONTHS 0 DAYS 26 If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scott City, Kansas

FATHER 13. NAME Murl Harpman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calhoun Co. Mich.

MOTHER 15. MAIDEN NAME  Evelyn Tompkins

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Plattsmouth, Neb.

17. INFORMANT (ADDRESS) Murl Harpman, 1122 Cedar St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Downs Grove Ill DATE 8/4/34

19. UNDERTAKER (ADDRESS) Ulysses - Dr. Carthage Mo

20. FILED Aug 11<sup>th</sup> 1934 J. B. Clenton Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 9<sup>th</sup> 1934

22. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1934, to Aug 9, 1934.

I last saw him alive on Aug 9<sup>th</sup> 1934 Death is said to have occurred on the date stated above, at 2:00 m.

The principal cause of death and related causes of importance were as follows:

Shulky Dysentery (Date of onset Aug 2<sup>nd</sup> 1934)

Other contributory causes of importance:

(Name of operation) \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1934

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 \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) J. B. Clenton, M. D.

(Address) \_\_\_\_\_

