

DEC 28 1935 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

42265

1. PLACE OF DEATH

County Vernon
Township Washington
City Waverly (No. 4)

Registration District No. 875
Primary Registration District No. 6162

File No.
Registered No. 225 St. Ward)

2. FULL NAME

HARRISON MRS EMMA FLORENCE

(a) Residence, No. State Hospital no 3 Nevada Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 30 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. H. Harrison

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1867

7. AGE YEARS 68 MONTHS ? DAYS ? IF LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

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) ?

13. NAME John Kitchen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iron Mountain Mo

15. MAIDEN NAME ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iron Mountain Mo

17. INFORMANT Hospital Records (ADDRESS) W. H. Harrison

18. BURIAL, CREMATION, OR REMOVAL PLACE Applin Mo DATE Dec 4th 1935

19. UNDERTAKER Hurlbut Funeral Home (ADDRESS)

20. FILED Dec 4 1935 M. Eickinger Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 4 19 35

22. I HEREBY CERTIFY, That I attended deceased from Aug 14 1935 to Dec 4 1935
I last saw her alive on Dec 4 1935 Death is said to have occurred on the date stated above, at 6:00 a.m.

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

Acute myocardial failure Date of onset 12-4-35
Chronic myocardial insufficiency
Arterio sclerosis (renal)

Other contributory causes of importance: None

Name of operation none Date of
What test confirmed diagnosis? Chemical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No 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 none
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) W. Pearce, M. D.

(Address) State Hosp. no 3, Nevada

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.

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