

REC'D SEP 16 1938

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

30134  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Shelby Registration District No. 827  
 (b) Township Claremont Primary Registration District No. 4500 Registered No. 12  
 (c) City Claremont (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lizzie Harris  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED (write name of HUSBAND OF (OR) WIFE OF) L. G. Harris

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 26, 1872

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>66</u>	<u>5</u>	<u>0</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. House wife  
 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) Helena Montana

FATHER  
 13. NAME George Krone  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER  
 15. MAIDEN NAME Sophie Steffen  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Mr Charles Lukey  
 (ADDRESS) Macon, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Claremont, Mo. DATE 8-29-38

19. FUNERAL DIRECTOR Stephens & Gooding  
 (ADDRESS) Macon, Mo.

20. FILED 9-1 1938 Ray Hamilton  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 26 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug 19 30, 1938, to Aug 26, 1938.  
 I last saw h. alive on Aug 26 1938 Death is said to have occurred on the date stated above, at 4 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Insufficient aortic valve of heart.  
ana  
 Other contributory causes of importance:  
Thyrotoxicosis.

Name of operation oments pexy Date of Mar 1938  
 What test confirmed diagnosis Barium sulfate test 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? no (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury no  
 Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify St Paul an  
 (Signed) Clarence mo, M. D.  
 (Address) \_\_\_\_\_

6669

RECEIVED

District Health Officer No. 10

District File Number 10-38-7

Date Filed 9-14-38

STATEMENT BY LICENSED EMBALMER

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

\_\_\_\_\_ L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

30134  
Do not use this space.

1. PLACE OF DEATH

(a) County Shelby Registration District No. 827  
 (b) Township Clarence Primary Registration District No. 1500 Registered No. \_\_\_\_\_  
 (c) City Clarence (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lizzie Harris

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
66 5 0

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as 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) \_\_\_\_\_

FATHER  
 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER  
 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 26 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Insufficient aortic valve of heart Date of onset \_\_\_\_\_

Operations performed for heart disease.

Other contributory causes of importance: Thyro Toxicosis

Name of operation Operations performed for heart disease 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 \_\_\_\_\_, 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 \_\_\_\_\_

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

If so, specify (Signed) D. L. Haslam M. D. (Address) Clarence Ind

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-30124