

DEB'D MAR 17 1939

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

7099  
Do not use this space.

1. PLACE OF DEATH

(a) County Linnigston Registration District No. 508  
(b) Township Chillicothe Primary Registration District No. 3026 Registered No. 21  
(c) City Chillicothe (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Mary E. Harper  
(a) Residence, No. 350 - W. Ave 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced-Widow  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Harper  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April - 18 - 1878  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 60 - 10 - 5  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
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) Jackson Twp. Linnigston Co. Mo.  
13. NAME James P. Rister  
14. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Germany  
15. MAIDEN NAME Rachel Smith  
16. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Illinois  
17. INFORMANT (ADDRESS) Mary Grace Harper Kansas City Mo.  
18. BURIAL, CREMATION, OR REMOVAL PLACE Edgewood Cmn' Feb. 27 - 1939  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) James D. Gordon Chillicothe Mo.  
20. FILED 2-27-1939 Donald M. Dowell M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 23 - 1939  
22. I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1939 to Feb 23, 1939  
I last saw her alive on Feb. 23, 1939. Death is said to have occurred on the date stated above, at 9:10 P.M.  
The principal cause of death and related causes of importance were as follows:  
Lobar Pneumonia Feb 18-39  
Date of onset Feb 18-39  
Other contributory causes of importance: 108  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? symptoms Was there an autopsy? no  
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? no  
If so, specify \_\_\_\_\_  
(Signed) Chillicothe Mo, M. D.  
(Address) Chillicothe Mo

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

59  
1  
2

District File No. 11

District File Number 38-13

Date Filed 3-7-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Emmer Shawar*

Registered Apprentice No.....

working under my personal supervision.

Signed *Emmer Shawar*

Licensed Embalmer No. 2640

P. O. Address *Chillicothe*

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

If this body is not embalmed, above space should be left blank.