

OCT 16 1939
Registration District No. **1775**

Primary Registration District No. **6023**

Registrar's No. **66**

1. PLACE OF DEATH:
(a) County **St. Francois**
(b) City or town **Rural - Marion Township**
(If outside city or town limits, write "RURAL" and name of township)(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **Cora Alice Harris**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Wm. C. Harris** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **Sept 8 1872**
(Month) (Day) (Year)

8. AGE: Years **67** Months **0** Days **6** If less than one day _____ hr. _____ min.

9. Birthplace **St. Francois Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **John S. Davis**
13. Birthplace **St. Francois Co. Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Verte May Cunningham**
15. Birthplace **St. Francois Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **John Davis**
(b) Address **Boone Lane Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 18-1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sedalia, Mo.**

18. (a) Signature of funeral director **Benjamin Ford Co.**
(b) Address **313 Benton St. Boone Lane Mo.**

19. (a) **Sept 16, 1939** (b) **N. W. Hawkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **1**
(c) City or town **Sedalia**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **14th**
year **1939** hour **8:20** minute _____ P. M.

21. I hereby certify that I attended the deceased from **Sept 14 1939** to **Sept 14 1939**;
that I last saw **her alive** on **Sept 14 1939**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis (from history)**
Due to _____
Due to _____

Duration

2 yrs

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature **Maurice J. Hawk** (Physician or other)
Address **Boone Lane Mo.** Date signed **9-15-39**

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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed C. J. Claywell
Licensed Embalmer No. 3706
P. O. Address Barren River Mo

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.