

Registration District No. 511 Primary Registration District No. 41.03 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Linn
 (b) City or town Laclede, Mo.
 (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 Thirty Years years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County Same
 (c) City or town _____ (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.

3. (a) PRINT FULL NAME Lucy J. Harris
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 30 year 1939 hour 5:30 minute _____ P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife James E. Harris 6. (c) Age of husband or wife if alive 77 years
 7. Birth date of deceased Jan. 21, 1872 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to Oct 30, 1939, that I last saw her alive on Oct 30, 1939 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>9</u>	<u>9</u>	hr. _____ min.

Immediate cause of death Coronary Heart Disease
 Duration Unknown

9. Birthplace Blue Mound Illinois (City, town, or county) (State or foreign country)
 10. Usual occupation House wife

Due to General Atherosclerosis Unknown
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) 94

11. Industry or business _____
 12. Name Christopher C. Hollier
 13. Birthplace _____ (City, town, or county) (State or foreign country) England
 14. Maiden name Nancy McKinney
 15. Birthplace _____ (City, town, or county) (State or foreign country) Illinois

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Charles Harris
 (b) Address Laclede, Mo.
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/1939 (Month) (Day) (Year)
 (c) Place: burial or cremation Laclede, Mo.
 18. (a) Signature of funeral director Mrs. Tharner
 (b) Address Laclede, Mo.
 19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

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? _____
 While at work? _____ (Specify type of place) (e) Means of injury _____
 28. Signature J. James Evans (M. D. or other) _____
 Address Bluefield Mo Date signed Oct 31, 1939

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

State of
Michigan

RECEIVED
Michigan Health Officer No. 111
License File Number 1139-1485
Date Filed NOV 8 1939

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 Me
W.G.Thorne, Laclede, Mo., Registered Apprentice No. 2876
working under my personal supervision.

Signed W.G.Thorne

Licensed Embalmer No. 2876

P. O. Address Laclede, Mo. Linn Co.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

36556
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 500
 (b) Township Laclede Primary Registration District No. 4303
 (c) City Laclede (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 Lucey J. 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 7 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.
67 9 9

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__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Oct 28 1937 Geo. O. Ploumar Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 30, 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__ 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:

Date of onset

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 _____, 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) J. P. Evans, M. D.

(Address) Brookfield

SUPPLEMENTARY

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

