

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38516

DEC 31 1939
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4280

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3835 Main St.
(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 Mrs. Clara Lee HARRISON, l. 25
8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Traverce Harrison 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased June 23 1889 (Month) (Day) (Year)

8. AGE: 50 Years 4 Months 13 Days If less than one day _____ hr. _____ min.

9. Birthplace Brooksville Kentucky (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business At Home
MOTHER FATHER { 12. Name Hayden Coona
13. Birthplace Ms Sterling Ky (City, town, or county) (State or foreign country)
14. Maiden name Myra Ellis
15. Birthplace Brooksville Ky (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Richard Canterbury
(b) Address 1014 Broadway, KLC. Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/9/39 (Month) (Day) (Year)
(c) Place: burial or cremation Augusta, Le Kentucky

18. (a) Signature of funeral director Melody-McGilley
(b) Address K. C. Mo.

19. (a) 11-9-39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo. (If outside city or town limits, write "RURAL")
(d) Street No. 3835 Main St. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 6 1939
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him / her alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Crushing Injury Head
Due to Multiph. Fractures +
Subdural
Due to Fall from 14' floor during fire
Other conditions Paralyzing
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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) Accident
(b) Date of occurrence 11-6-39
(c) Where did injury occur? Kansas City, Jackson Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
11 Hotel (Specify type of place) (e) Means of injury
23. Signature Russell W. Jones (M. D. or other) _____
Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

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.

50M-6-17-39
Rev. 5-17-39
U. S. G. P. 1 X 1931

Mr. Chamberlain mailed to Dr.
Collinson Washington - his
Code 180

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.....
Licensed Embalmer No.....
P. O. Address.....

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.

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

Do not use this space. *X*

1. PLACE OF DEATH

County Jackson
Township M.C.
City M.C. (No. —)

Registration District No. 399
Primary Registration District No. 1022-

File No. 38516
Registered No. 4280-
St. _____ Ward _____

2. FULL NAME

Clara L. Harrison
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (writes 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.
50 4 13

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

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS)

20. FILED 11/9/39 m.m. Crow Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 6, 1934

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:

Crushing injury to head, multiple fractures
Date of onset 11-6-34

Other contributory causes of importance:
fall from 12th floor during fire in building, not a conflagration

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? acc. Date of injury 11-6-1934
Where did injury occur? M.C.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Hotel

Manner of injury _____
Nature of injury 100

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) _____, M. D.
(Address) _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

TEMPORARY

