

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.

JAN 22 1940

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

Do not use this space.

43293

1. PLACE OF DEATH

County *Andrew*

Township *1st*

City *1st*

(No. _____)

St. _____

Ward _____

Registration District No. *288*

Primary Registration District No. *5706*

File No. _____

Registered No. _____

2. FULL NAME *Clay Harrison*

(a) Residence, No. _____

(Usual place of abode)

Ward _____

(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 *M.*

4. COLOR OR RACE *W.*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *3-25-1868*

7. AGE

YEARS *71*

MONTHS *8*

DAYS *26*

IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as planer, sawyer, bookkeeper, etc. *Carpenter*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Labor*

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) *Paris*

13. NAME *William Harrison*

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

15. MAIDEN NAME *Ann Brown*

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

17. INFORMANT (ADDRESS) *Wesley Lemonds*

18. BURIAL, CREMATION, OR REMOVAL PLACE *County Courthouse*

DATE *10-22*

19. UNDERTAKER (ADDRESS) *County Courthouse*

20. FILED *1-2*

1940 *Wesley Lemonds* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-21*, 19*39*

22. I HEREBY CERTIFY, That I attended deceased from *4-15*, 19*38* to *10-21*, 19*39*

I last saw him alive on *10-20*, 19*39* Death is said to have occurred on the date stated above, at *2 P.* m.

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

*Uterine hyperperistalsis
decompensated heart*

Other contributory causes of importance:
General Arteriosclerosis

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) *Wesley Lemonds* M. D.

(Address) *County Courthouse*

RECEIVED

District Health Officer No. 3,

Health File Number 140-777

Date 1/16/40