

11.15 am.

CAN 21350

Dr Cooper

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

44253
Do not use this space.

1. PLACE OF DEATH

(a) County Platte Registration District No. 600
(b) Township Central Primary Registration District No. 0872
(c) City St. Louis, Mo. (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Peggy Mae Harrison
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 11 - 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 6

OCCUPATION
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) St. Louis, Mo.

FATHER
13. NAME Winton Harrison

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denton, Mo.

MOTHER
15. MAIDEN NAME Maggie Bell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

17. INFORMANT (ADDRESS) Mr. Winton Harrison

18. BURIAL, CREMATION, OR REMOVAL PLACE Coleman Cemetery DATE 11-18-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. P. Harris

20. FILED 12/28/39 L. J. O'Rourke Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1939, to Nov 17, 1939

I last saw him alive on Nov. 12, 1939. 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:
Inadequate nutrition

Other contributory causes of importance: 158

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) R. E. Cooper, M. D.
Cooper, Mo. (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.

1 X 16303

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.....

Halter M. Day....., Registered Apprentice No.
working under my personal supervision.

Signed Halter M. Day.....

Licensed Embalmer No. 4060.....

P. O. Address New Madrid, 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.