

FEB 7 1940

FILED FEB 7 1940

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

2526
Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 878
 (b) Township _____ Primary Registration District No. 4222 Registered No. 6
 (c) City Fayette (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

Eliza B. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR Widowed
PROVIDED FOR IN THE WORD

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7/2nd 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
57 ✓ 6 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
 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) AND (STATE OR COUNTRY) Missouri

FATHER 13. NAME George Forbes

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

MOTHER 15. MAIDEN NAME Sarah Mc Kee

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

17. INFORMANT (ADDRESS) Edieth Forbes, Fayette, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE City Semetary DATE I/ 9th 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Guy T. Halley, Fayette, Mo.

20. FILED Feb 5 1940 V. O. Borham Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/7th 1940

22. I HEREBY CERTIFY, That I attended deceased from 7-5, 1939, to 1-7, 1940
 I last saw her alive on 1-7, 1940 Death is said to have occurred on the date stated above, at 7:00 a.m.
 The principal cause of death and related causes of importance were as follows:

Acute Arterial Coma Date of onset 1-5-40
121
 Other contributory causes of importance: Cardio-Vascular Renal Disease 1936

Name of operation None Date of _____
 What test confirmed diagnosis? None Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No 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? No
 If so, specify _____
 (Signed) Dr. Bloom, M. D.
 (Address) Fayette Mo

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.

State Division

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 7/1/40

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25-26
Do not use this space.

1. PLACE OF DEATH
 (a) County Howard Registration District No. 378
 (b) Township..... Primary Registration District No. 4222 Registered No.....
 (c) City Fayette (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 Eliza B. Harris
 (a) Residence, No. Fayette mo 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) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS 58 MONTHS 6 DAYS 5 If LESS than 1 day, hrs. or min.

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)
Feb. 5, 1940 V. O. Pontman
 20. FILED Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7-40

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) W. A. Bloom, M. D.
 (Address) Fayette mo.

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.

