

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 117

BUREAU OF THE CENSUS  
APR 23 1940

Registration District No. 547

Primary Registration District No. 3029-5738

Registrar's No.

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Near Hannibal  
(c) Name of hospital or institution: Masonic Home  
(d) Length of stay: In hospital or institution 20 yr 5  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion  
(c) City or town Near Hannibal  
(d) Street No. Masonic Home  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME Jordan Harmon  
3. (b) If veteran name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month March day 26<sup>th</sup>  
year 40 hour 4 PM minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced ✓  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3/1/40, 19\_\_\_\_, to 3/28/40, 19\_\_\_\_;  
that I last saw him alive on 3/28/40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Apoplexy Duration \_\_\_\_\_

8. AGE: Years about 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Trenton MO  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Teacher

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Jordan Harmon  
13. Birthplace Trenton MO  
(City, town, or county) (State or foreign country)  
14. Maiden name Heppard  
15. Birthplace Mo  
(City, town, or county) (State or foreign country)

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? Yes  
(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant's own signature Wm McDaniel  
(b) Address Masonic Home

17. (a) Burial (b) Date thereof 3-26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reburied  
18. (a) Signature of funeral director Geo E Roberts  
(b) Address Hannibal, Mo

19. (a) 3-30-40 (b) W.D. Fisher  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Hannibal Mo Date signed 3/27/40

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.

---

---

**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  
STANDARD CERTIFICATE OF DEATH

State File No. 11702  
Registrar's No. 117

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 247

Primary Registration District No. 2738

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Merion  
(b) City or town Wagon Bus  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Jordan Hamner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race col 6. (a) Single, widowed, married, divorced single  
(b) Name of husband or wife (single) 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years abt 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) May 10, 1946 (b) E. M. Rucke (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day 26  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature H. P. McInerney (Dr. or other) \_\_\_\_\_  
Address Hammer Date used \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11702 (1940)