

No. 2  
-11-10-39  
5-17-39  
P1 X2142

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

12541

State File No. \_\_\_\_\_

Registration District No. 799

Primary Registration District No. 4479

Registrar's No. 7.9

**1. PLACE OF DEATH:**

(a) County Saline

(b) City or town Slater  
(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 50 years  
years, months or days)

9. (a) PRINT FULL NAME Robert Henry Harris

9. (b) If veteran, name war X

8. (c) Social Security No. X

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if \_\_\_\_\_ years

7. Birth date of deceased Feb 28 1855  
(Month) (Day) (Year)

8. AGE: 85 Years 0 Months 27 Days  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Saline Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

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

MOTHER FATHER { 12. Name Prose Harris

13. Birthplace Don't know  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace: Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant James W Harris

(b) Address Slater Mo

17. (a) Harris Cemetery (Place thereof) 3-27-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 10 miles NW Slater

18. (a) Signature of funeral director James A. Baker

(b) Address Slater Mo

19. (a) 3 26 (Date received local registrar) W. M. Little (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Saline

(c) City or town Slater  
(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 3 day 25  
year 1948 hour 8 minute 40 M.

21. I hereby certify that I attended the deceased from 3-4-1948 to 3-4-1948  
that I last saw him alive on March-4-1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: myocarditis - mental condition

Due to: Suplex

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

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

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

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) \_\_\_\_\_

(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 M. C. Shuggins (M. D. or other) \_\_\_\_\_  
Address Slater Mo Date signed \_\_\_\_\_

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

Date Filed 4-16-70

District File Number

District Health Officer No. 8,

RECEIVED

**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

working under my personal supervision.

Registered Apprentice No.

Signed Jones

Licensed Embalmer No. 3187

P. O. Address Low 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.

By J. E. Jones