

No. 2
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FEDERAL MAY 20 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15712**

Registration District No. **667**

Primary Registration District No. **5863**

Registrar's No. **38**

1. PLACE OF DEATH:

(a) County **Peru**
(b) City or town **Rural, Peru, 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 **2**
(Specify whether)

In this community **2**
years, months or days

3. (a) PRINT FULL NAME **Phillie Harry, I.O.D.**

3. (b) If veteran, name war **V**
3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Harry**
6. (c) Age of husband or wife if alive **30** years

7. Birth date of deceased **12-1-1910**
(Month) (Day) (Year)

8. AGE: Years **34** Months **4** Days **23**
If less than one day hr. min.

9. Birthplace **Cottonwood Point, MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **Allen Harry**

13. Birthplace **Tenn**
(City, town, or county) (State or foreign country)

14. Maiden name **Genevieve Foster**

15. Birthplace **Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Gladys Harry**

(b) Address **Warrentonville, Mo**

17. (a) **Burial** (b) Date thereof **April 4, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Cemetery**

18. (a) Signature of funeral director **W. J. Guthing**
(b) Address **Warrentonville, Mo**

19. (a) **Apr. 10, 1940** (b) **Oda Martin**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Peru**

(c) City or town **Cottonwood Point**
(If outside city or town limits, write "RURAL")

(d) Street No. **R #1**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? **0** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **apr**
year **1940** hour **3-30** minute **A.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 **Found in and laid care named Wessado year 1932, at Cottonwood Point MO**

Due to **suicidal from smoke and Busnel, to death**

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) **accident**

(b) Date of occurrence **April 3-1940**

(c) Where did injury occur? **Cottonwood Point, MO**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
585 Public Place
(Specify type of place)

While at work? **Y** (a) Means of injury _____

23. Signature **F. J. Guthing, J.P. Notary**
Address **Peru Mo 673** Date signed **4-2-40**

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

5-40-9.

151
194

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 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 15712

Registration District No. 657

Primary Registration District No. 3863

Registrar's No.

1. PLACE OF DEATH:

(a) County Permiest
(b) City or town Permiest T.P.
(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 _____ years, months or days)

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.

3. (a) PRINT FULL NAME Willie Harry

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased 12-1-1904
(Month) (Day) (Year)

8. AGE: Years 35 Months 4 Days 2 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) June 8, 1940 (b) Ada Martin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH month apr day 3
year 1940 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?
_____ (Specify type of place)

While at work? _____ Means of injury _____

23. Signature F. J. Gitting (M. D. or other) _____

Address Fowler, Ind. Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Registration District No. 657

Primary Registration District No. 5863

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Pemiscot T.P.
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Willie Harvey

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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)

8. AGE: Years 34 Months 4 Days 2 If less than one day _____ 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) _____ (b) _____ (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 Apr day 3 year 1946 hour _____ minute _____ M.

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

Immediate cause of death _____
suffered from smoke
and burned to death.
Willie Harvey was drunk and his
car caught on fire he died
in his car and the smoke &
fire burnt and smaked his to death.
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____
210 B.
7.6

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 J. J. Keating M. D. or other _____
Address Taylor mo _____ Date signed _____

SUPPLEMENTARY

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