

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. ~~22~~ 944

Primary Registration District No. 5438

Registrar's No. 28

39

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Taylor Township  
~~SPRINGFIELD~~ TURNERS

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days) 6 7/10

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

(c) City or town Turners  
(If outside city or town limits, write "RURAL") Rural

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

3. (a) PRINT FULL NAME BILLIE DEAN HARRIS

MEDICAL CERTIFICATION

8. (b) If veteran,  name war \_\_\_\_\_

8. (c) Social Security No.  \_\_\_\_\_

20. DATE OF DEATH: Month May day 2 nd  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex male

6. Color or race white

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

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

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

7. Birth date of deceased January 2 1928  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him in dead alive on May 2 1940;  
and that death occurred on the date and hour stated above.

8. AGE: Years 12 Months 4 Days 0 If less than one day \_\_\_\_\_  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Brain Suffocation

Due to Caught in burning coal

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

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

Other conditions (Include pregnancy within 3 months of death) 18 1/2

10. Usual occupation Child

11. Industry or business Child at Home

12. Name Jack Harris

13. Birthplace Mo. O  
(City, town, or county) (State or foreign country)

14. Maiden name Walter Harris

15. Birthplace Mo. O  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Jack Harris

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof May 7 1940  
(Burial, cremation, or removal) Oak Grove Cem. (Month) (Day) (Year)

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

18. (a) Signature of funeral director J. W. Kugler

(b) Address Springfield, Mo.

19. (a) 5-6-1940 (b) Hans Greier  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 5/2/40

(c) Where did injury occur? Turners Greene Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On Farm

While at work? at home (Specify type of place)

(e) Means of injury two stones

23. Signature R. M. White (M. D. or other) S

Address Turners Greene County Date signed 5/12/40

RECEIVED

Greene County Health Office,

County File Number 40-6-28

Date Filed 6-10-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> embalmed by me, or by No Embalming, 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.**