

STANDARD CERTIFICATE OF DEATH

State File No. 19744

Registrar's No. 2

Registration District No. _____

Primary Registration District No. 1-10-1

1. PLACE OF DEATH:

(a) County Stoddard *Missouri, 17 mi*
(b) City or town 2 Miles W. Morehouse
(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 6 Weeks
years, months or days)

3. (a) PRINT FULL NAME Chester Ray Harper

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

4. Sex Male 5. Color or race White 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 Feb. 29 1940
(Month) (Day) (Year)

8. AGE:	Years <u>2</u>	Months <u>1</u>	Days <u>14</u>	If less than one day hr. _____ min. _____
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9. Birthplace 2 Miles W. Morehouse Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Wade Harper

18. Birthplace Clinton Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Lillian Pearson
(City, town, or county) (State or foreign country)

16. Birthplace Steele Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wade Harper
(b) Address Morehouse Mo.

17. (a) Burial (b) Date thereof 4/13/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Essex, Mo.

18. (a) Signature of funeral director John C. Carter

(b) Address Steele Mo.

19. (a) 4/13/40 (b) J.P. Brandon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard

(c) City or town 2 Miles W. Morehouse,
(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 April day 12th
year 1940 hour 7 minute _____ A. M.

21. I hereby certify that I attended the deceased from 4-6-40
_____, 19____, to 4-12-40, 19____.

that I last saw her alive on 4-12-40, 19____.

and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition Duration weeks

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Am. Davis (M. D. or other) M.D.

Address Morehouse Date signed 4-12-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo
 USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 I X 1931

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RECEIVED

District Health Officer No. 2

District File Number 640-1160

Date Filed 6/20/48

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.....

not embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed John Albritton

Licensed Embalmer No. 2941

P. O. Address Inkis ton

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. 19744

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 6101

Registrar's No. 2

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

1. PLACE OF DEATH

(a) County Stoddard

(b) City or town Richland, 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 _____ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Chester Ray Harper

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 _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months 1 Days 14 If less than one day _____ hr. _____ 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(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.

20. DATE OF DEATH _____ month apr day 12 year 1940 hour _____ minute _____ M.

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

Immediate cause of death malnutrition Duration _____

Due to Deitying deficiency

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 158

Major findings: _____ Of operations _____

Of autopsy _____

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 S. W. Sarno (M. D. or other) _____

Address warehouse Date signed _____

SUPPLEMENTARY

