

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24222
Registrar's No. 2532

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Warrens City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether
In this community Non-Resident
years, months or days)

3. (a) PRINT FULL NAME HENRY A. HARRIG

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

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

6. (b) Name of husband or wife Miss Arthur's Harrig 6. (c) Age of husband or wife if alive 12 1/2 years

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

8. AGE: Years abt 33 Months Days If less than one day hr. min.

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

10. Usual occupation Don't know

11. Industry or business Don't know

12. Name Don't know

18. 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 H. S. Mayberry

(b) Address 2315 Linwood Blvd

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 7-15-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Osaka Hosp

18. (a) Signature of funeral director H. S. Mayberry

(b) Address 2315 Linwood Blvd

19. (a) July 15, 1940 (Date received local registrar) M. M. Crome (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County
(c) City or town Manhattan
(If outside city or town limits, write "RURAL")
(d) Street No. 412 N. 11th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14 year 1940 hour 8 minute 25 P. M.

21. I hereby certify, that I attended the deceased from June 27, 1940, to July 14, 1940, that I last saw him alive on July 14, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary + cerebral compression, medullary edema and punctate hemorrhages brain stem Duration 12 days

Due to Thrombosis of left jugular bulb 82% Duration 12 days

Due to Meniere's disease (status for 4 years) Duration 9 months

Other conditions (Include pregnancy within 3 months of death)

Major findings: Massive lamination and edema of cerebellum PHYSICIAN
Of operations As above. 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 Frank R. Dechenon (M. D. or other) M.D.

Address 1630 Professional Bldg Date signed 7-14-40

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

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

R. E. Snow

Registered ~~Apprentice~~ ^{Emb} No. *2560*

working under my personal supervision.

Signed

W. Mayberry

Licensed Embalmer No. *2934*

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.