11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

SEP 16 1940

Registration District No. 89

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28064

Primary Registration District No. 5-13-4053

Registrar's No. 249

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Harwell
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2
(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) 120

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler

(c) City or town Harwell
(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 DORTHY MAE HARRIS

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex female

5. 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 July 19 (Month) (Day) 1940 (Year)

8. AGE: Years | Months | Days 26 | If less than one day hr. min.

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

10. Usual occupation ✓

11. Industry or business ✓

FATHER
12. Name Clarence Harris
13. Birthplace Crawford (City, town, or county) Ill. (State or foreign country)

MOTHER
14. Maiden name Lela Sheets
15. Birthplace Unk (City, town, or county) Ark (State or foreign country)

16. (a) Informant Clarence Harris
(b) Address Harwell Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 40 (Month) (Day) (Year)
(c) Place: burial or cremation Black Creek

18. (a) Signature of funeral director Minnie Gish
(b) Address Naylor Mo

19. (a) 8-20/40 (Date received local registrar) (b) O Clutsinger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
year 1940 hour 3 minute P M.

21. I hereby certify that I attended the deceased from Aug 14 1940, 19 , to Aug 15 1940
that I last saw her alive on Aug 14 1940
and that death occurred on the date and hour stated above.

Immediate cause of death gastro-intestinal autointoxication

Due to fermentation of food

Due to

Other conditions Vaccination pertussis
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy no

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?
8a (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address Naylor Mo Date signed 8/16/40

(Licensed Embalmer's Statement on Reverse Side)

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28064

Registration District No. 89 Primary Registration District No. 405-3 Registrar's No. 249

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Harwell
(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)

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 Dorothy May Harris
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
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 | Months | Days 26 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 8-20-40 (Date received local registrar) (b) O. C. Cutsinger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
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 Gastro Intestinal Autotoxication
Due to Fermentation of food
Due to
Other conditions Vaccanative pertussis or as prophylaxis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
She did not have
Of autopsy pertussis

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature H. E. White (M. D. or other)
Address Naylor Mo Date signed