

FILED SEP 23 1940  
Registration District No. 2319

Primary Registration District No. 4286

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Lewis  
(b) City or town Union  
(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 2  
In this community 60 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Hilborn Hilton Harris

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Virginia Thomas 6. (c) Age of husband or wife if alive 16 years (Day) (Year)

7. Birth date of deceased Year 1863 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>8</u>	<u>26</u>	hr. min.

9. Birthplace Adams Co. Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Physician

11. Industry or business M.D.

12. Name Hilborn Harris

13. Birthplace Denny, Iowa (City, town, or county) (State or foreign country)

14. Maiden name Hanna Hoffert

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

16. (a) Informant's own signature Mrs. Juencia Bond

(b) Address Denny Ill.

17. (a) Burial (b) Date thereof 8-15-1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parsonage

18. (a) Signature of funeral director F. S. Kelly

(b) Address Carroll Mo.

19. (a) Aug. 13 (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis  
(c) City or town Union  
(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 August day 12 year 1940 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct. 19 1939, to Aug. 12 1940 that I last saw him alive on Aug. 12 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 5 min.

Due to Coronary Thrombosis

Due to

Other conditions 44 (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) none

(b) Date of occurrence none

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none  
While at work? (Specify type of place) (e) Means of injury

23. Signature F. W. Jennings (M. D. or other) Address Carroll Mo. Date signed Aug. 14

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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.....

*W. D. Kelly*

Registered Apprentice No. *1905*

working under my personal supervision.

Signed.....

*W. D. Kelly*

Licensed Embalmer No. *1905*

P. O. Address *Cambridge, Mass.*

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **28927**

Registration District No. **477**

Primary Registration District No. **4286**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County **Lewis**  
(b) City or town **Canon**  
(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

**Hilburn Milton Harris**

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 **wid**  
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 **76** Months **8** Days **36** If less than one day hr. 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) **Aug 13, 1940** (b) **P. W. Jennings, M.D.**  
(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. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Aug** day **17** 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 \_\_\_\_\_

Duration

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 **P. W. Jennings** (M. D. or other) \_\_\_\_\_  
Address **Canon Mo** Date signed \_\_\_\_\_

SUPPLEMENTAL

