

No. 1-10-39  
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X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31894

Registration District No. 206

Primary Registration District No. 5378

Registrar's No.

1. PLACE OF DEATH:

(a) County De Witt  
(b) City or town Arnett Mo  
(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) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County De Witt  
(c) City or town Arnett  
(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 Samuel Aaron Harrison

3. (b) If veteran, name war Civil 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased April 10 1842  
(Month) (Day) (Year)

8. AGE: Years 98 Months 4 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Aaron Harrison

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

14. Maiden name Rachel Jones

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

16. (a) Informant My R. S. Friel

(b) Address Rural

17. (a) (Burial, cremation, or removal) Arnett Mo (b) Date thereof Sept 11 1940  
(Month) (Day) (Year)

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

18. (a) Signature of general director Friel (b) Address Rural Mo

19. (a) August 31, 1940 (b) F. E. Butler  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30 year 1940 hour \_\_\_\_\_ minute 45 P. M.

21. I hereby certify that I attended the deceased from August 29, 1940, to Aug 30, 1940; that I last saw him alive on Aug 30, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage (Pt.) Duration 2 1/2 hrs.

Due to Arteriosclerosis

Due to PT

Other conditions (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) \_\_\_\_\_

(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? \_\_\_\_\_

240 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature James B. Jones (M. D. or Dr.)  
Address 616 Pine St., Balla, Mo. Date signed 8-31-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 1040979

Date Filed \_\_\_\_\_

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. 339

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **31894**

Registration District No. **266**

Primary Registration District No. **5378**

Registrar's No. **82**

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

1. PLACE OF DEATH:

(a) County **De Witt**

(b) City or town **Watkins, Mo.**  
(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, month or days (Specify whether)

3. (a) **PRINCE FULL** **Samuel Aaron Harrison**

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

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

8. AGE:	Years	Months	Days	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) (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) **November 19, 1940** (Date received local registrar) (b) **F. E. Smith, M.D.** (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH month **aug** day **30** year **1940** hour minute M.

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

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

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

23. Signature **James B. Jones** (M. D. or other) Address **Rolla, Mo.** Date signed

