

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.

NOV 15 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

34920  
Do not use this space.

1. PLACE OF DEATH

(a) County Butter Registration District No. 89 626  
(b) Township Raccoon Primary Registration District No. 513  
(c) City Marion (d) Street No. \_\_\_\_\_ Registered No. 319  
(If death occurred in Hospital or Institution, write its name (instead of street and number))  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Abbie Harmon  
(a) Residence, No. Upper bluff R 3 St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert Austin Harmon  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about 1865  
7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
75  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife  
9. Industry or business in which work was done, as saw mill, bank, etc. work at home  
10. Date deceased last worked at this occupation (month and year) to present time 11. Total time (years) spent in this occupation life  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lincoln Mo.  
13. NAME William Nitzner  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hamburg Germany  
15. MAIDEN NAME Katie White  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland  
17. INFORMANT (ADDRESS) J. W. Harmon  
18. BURIAL, CREMATION, OR REMOVAL PLACE McGroocem cemetery 10/21/1940  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. Daniel Funeral Home, Marion, Mo.  
20. FILED 10/26 1940 H. O. Obeltinger Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 20 1940  
22. I HEREBY CERTIFY, That I attended deceased from Oct 19 1940 to Oct 21 1940  
I last saw her alive on Oct 19 1940. Death is said to have occurred on the date stated above, at 6 a. m.  
The principal cause of death and related causes of importance were as follows:  
apoplexy  
Other contributory causes of importance: hypertension  
Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? clinical Was there an autopsy? no  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_ (Signed) W. E. White, M. D.  
(Address) Marion Mo.

**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.....

*H. P. Gook*

Registered Apprentice No.....

working under my personal supervision.

Signed.....

*H. P. Gook*

Licensed Embalmer No.....

*4106*

P. O. Address.....

*Smith Mo*

**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.**