

Registration District No. 318 NOV 7 1940

Primary Registration District No. 2001

865

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: Springfield Baptist Hospital
(d) Length of stay: In hospital or institution 1 week
In this community 1 week
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barton
(c) City or town Golden City
(d) Street No. _____
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME LOUISA J. HARRAH

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

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

6. (b) Name of husband or wife Elmer C. Harrah 6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased August 24 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 1 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Willie Maxey
13. Birthplace Unknown Ky.
14. Maiden name Unknown New York
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Veda B. Harrah
(b) Address Unknown

17. (a) Burial (b) Date thereof Oct. 24, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D. O. F. Cem. Golden City, Mo.

18. (a) Signature of funeral director G. A. Phillips
(b) Address Golden City, Mo.

19. (a) 10-24-40 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
year 1940 hour 9 minute 45A M.

21. I hereby certify that I attended the deceased from Oct 16
1940, to Oct 23, 1940
that I last saw her alive on Oct 23, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis with uremia Duration 10d.

Due to _____

Due to 131

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? no
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Wm D Callaway (M. D. or other) _____
Address Springfield Mo Date signed 10/24/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....
....., 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 with the above constitutes grounds for revocation of license.)

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

X