

FILED JAN 8 1940
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Kansas City, 3646 Charlotte
(b) City or town Kansas City, 3646 Charlotte
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3646 Charlotte 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 22 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Kansas City, 3646 Charlotte
(If outside city or town limits, write "RURAL")
(d) Street No. 3646 Charlotte
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Elizabeth Harrison

8. (b) If veteran, name war No 3. (c) Social Security No. MO

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

6. (b) Name of husband or wife James Coleman Harrison 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 14 1852
(Month) (Day) (Year)

8. AGE: Years 87 Months 11 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

12. Name William Crawford

13. Birthplace Philadelphia Penn.
(City, town, or county) (State or foreign country)

14. Maiden name E. L. A. Atterton

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

16. (a) Informant W. K. R. B. J.

(b) Address Bellefontaine Mo.

17. (a) Burial (b) Date thereof 12-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adrian Mo.

18. (a) Signature of funeral director Leath & Sif

(b) Address Adrian Mo.

19. (a) 12-11-40 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11
year 1940 hour 5 minute A.M.

21. I hereby certify that I attended the deceased from 12 5 40
_____, 19____, to 12 16, 1940;

that I last saw him alive on 12 10, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
bronchial

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy no

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 1

23. Signature J. B. B. B. (M. D. or other) _____

Address City Date signed 12-11-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. 3650

P. O. Address Adrian 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.