DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42398

JAN 25 1941

Registration District No. 284

Primary Registration District No. 54044 4170

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Holcomb (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cochan Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution About 4 days (Specify whether

In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin

(c) City or town Holcomb (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.

3. (a) PRINT FULL NAME Betty J. Harper

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced —

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Aug-14-1930 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
10	1	12	hr. min.

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

10. Usual occupation School Girl

11. Industry or business —

FATHER
12. Name J. B. Harper
13. Birthplace Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Hazel Badge
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Father J. B. Harper

(b) Address Holcomb Mo.

17. (a) Sept. 27-Burial (Burial, cremation, or removal) (b) Date thereof Sept-27-40 (Month) (Day) (Year)

(c) Place: burial or cremation Stanfield

18. (a) Signature of funeral director Landers Funeral Home

(b) Address Campbell Mo.

19. (a) 1-10-41 (Date received local registrar) (b) J. A. Anderson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26 year 1940 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from Sept 24, 1940, to Sept 26, 1940 that I last saw her alive on Sept 26, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Skull

Due to Automobile accident

Due to

Other conditions Concussion of brain (Include pregnancy within 3 months of death) & Hemorrhage

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? On highway 25 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 250 (Specify type of place)

While at work? (e) Means of injury

23. Signature Amy E. Cochran (M. D. or other)

Address Holcomb Date signed Mo

(Licensed Embalmer's Statement on Reverse Side)

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Primary Registration District No. ..... Registrar's No. .....

RECEIVED

District Health Officer No. 2

District File Number 14512

Date Filed 1/14/42

1. PLACE OF DEATH:

(a) City or town .....

(b) Name of hospital or institution: (If outside city or town limits, write "RURAL" and name of township)

(c) Length of stay: In hospital or institution ..... (If not in hospital or institution, write street number or location)

In this community ..... (Specify whether years, months or days)

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.

3. (a) FULL NAME PRINT

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex .....

5. Color or race .....

6. (a) Single, widowed, married, divorced .....

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 ..... Months ..... Days ..... If less than one day ..... hr. ..... min.

9. Birthplace .....

10. Usual occupation .....

11. Industry or business .....

12. Name .....

13. Birthplace ..... (City or county) (State or foreign country)

14. Residence .....

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

16. (a) Informant .....

(b) Address .....

17. (a) Date of death ..... (Month) (Day) (Year)

(b) Place: burial or cremation ..... (Street, crematorium, or removal)

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) Registrar's signature .....

(b) Date received by registrar .....

20. DATE OF DEATH: Month ..... day ..... year ..... 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 .....

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? ..... (Specify type of place)

MEDICAL CERTIFICATION

Major findings: .....

Or, autopsy .....

PHYSICIAN

Underlying cause to which death should be attributed.

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 ..... 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, fact should be so stated above.

(Licensed Embalmer's Statement on Reverse Side)

FOLDING

BITE PERMANENT—USE PERMANENT BLACK INK—MAKE A PERMANENT RECORD

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42398

Registration District No. 286 Primary Registration District No. 4170 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Holcomb
(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)

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.

3. (a) PRINT FULL NAME Betty Jo Harper

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced

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	Months	Days	If less than one day
	10	1	12	hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Fract. Skull
automobile accident

Due to Automobile accident
Collision with another automobile

Due to Concussion of Brain

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 210 M 22

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) Auto Collision with another auto
(b) Date of occurrence Sept 23
(c) Where did injury occur? On highway 75
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On Hgw 25
(Specify type of place)
While at work? (e) Means of injury

23. Signature John E Cochran (M. D. or other)
Address Holcomb Mo Date signed