

No. 2
4-13-40
5-17-40
I. 2231L

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3173**
Registrar's No. **6**

Registration District No. **467**

Primary Registration District No. **4280**

Registrar's No. **6**

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

1. PLACE OF DEATH:

(a) County **Lawrence**

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

(c) Name of hospital or institution:
23 West Anderson
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **none**
(Specify whether)

In this community **3**
years, months or days

3. (a) PRINT FULL NAME **Isaac T. Harrison**

3. (b) If veteran, name war **no**

3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **white**

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

6. (b) Name of husband or wife **Amanda Harrison**

6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **March 19**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
67	10	8	hr. min.

9. Birthplace **Christian**
(City, town, or county) (State or foreign country) **V.O**

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER

12. Name **Joseph Harrison**

13. Birthplace **unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Larah Gold**

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

16. (a) Informant **Charles Harrison**

(b) Address **Springhill 710**

17. (a) **Burial** (b) Date thereof **Jan 29, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wade Cemetery**

18. (a) Signature of funeral director **Charles Harrison**

(b) Address **2394 Church of Lawrence Mo**

19. (a) **2-1-41** (b) **R. D. Lawan, MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Green**

(c) City or town **Republic**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) **1**

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **27**
year **1941** hour **12** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Jan 4**, 19**41**, to **Jan 27**, 19**41**; that I last saw him alive on **Jan 27**, 19**41**; and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis**

Duration **3 days**

Due to **Ch. myocardi**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **ASH**

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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? **418**
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **R. D. Lawan** (M. D. or other) **0**

Address **Republic, Mo** Date signed _____

RECEIVED

District Health Officer No. 6,

District File Number 141-197

Date Filed FEB 4 1921

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.....

Myself....., Registered Apprentice No. None
working under my personal supervision.

Signed Brian L. Marsh.....

Licensed Embalmer No. 3812.....

P. O. Address Amherst Mo.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31737

Registration District No. 467

Primary Registration District No. 4280

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
23 W. Anderson St.
(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)

3. (a) PRINT FULL NAME Isaac T. Garrison
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 M

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
67 10 8 hr. min.

9. Birthplace Christian County, Mo.
(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) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-28-41 (b) R. D. Cowan, M.D.
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene
(c) City or town Republic
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 27
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h_____ 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 _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature R. D. Cowan (M. D. or other)

Address Aurora, Mo Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

in vlg

