

REC'D MAY 19 1941

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 14440

Registration District No. 289

Primary Registration District No. 5407

Registrar's No. 15

I. PLACE OF DEATH:

(a) County: Dunklin
(b) City or town: Malden Rural
(c) Name of hospital or institution: Patton Hall
(d) Length of stay: In hospital or institution. About 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Dunklin 35
(c) City or town: Malden Rural
(d) Street No.
(e) Citizen of foreign country? (Yes or No)

3. (a) PRINT FULL NAME: Ethel Harmon

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

4. Sex: Female! 5. Color or race: WHITE 6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife: Lee Harmon 6. (c) Age of husband or wife if alive: 45 years
7. Birth date of deceased: Aug 26 1902

8. AGE: Years 38, Months 7, Days 9, hr. min.

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

10. Usual occupation: Housewife

11. Industry or business:
12. Name: Robert A. Simmas
13. Birthplace: Ky. (City, town, or county) (State or foreign country)
14. Maiden name: Ada Robertson
15. Birthplace: Ark. (City, town, or county) (State or foreign country)

16. (a) Informant: Husband Lee Harmon

(b) Address: Malden Mo. Rural

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: April-6-41

(c) Place: burial or cremation: malden cemetery

18. (a) Signature of funeral director: Landess Funeral Home

(b) Address: 6 Campbell Mo.

19. (a) 4-6-1941 (Date received local registrar) (b) S.B. Mitchell (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 5 year: 41 hour: 5 minute: 138 M.

21. I hereby certify that I attended the deceased from April 2 1941 to April 5 1941 that I last saw her alive on April 5 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Chl. atretical obstetrical April 4/41

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: [Signature] (M.D. or other) Address: [Address] Date signed: [Date]

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

MOTHER FATHER

12212

RECEIVED

District Health Officer No

District File Number 041-5

Date Filed 5/8/74

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.....

Christine Sanders

Registered Apprentice No. 245

working under my personal supervision.

Signed C. W. Sanders

Licensed Embalmer No. 2289

P. O. Address Campbell

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14440

Registration District No. 289

Primary Registration District No. 2407

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Carlton Hill T.P.  
(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)

3. (a) PRINT FULL NAME Ethel Harmon  
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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years Months Days If less than one day  
38 7 9 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: month Apr day 5  
year 1941 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 Intestinal obstruction Duration \_\_\_\_\_  
non

Due to Adhesion from Body of ovum to Intestines  
Due to intestine passed in to small opening and stuck

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ 12 2 10

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Euston Ventura (M. D. or other) MD

Address 80th Alder Date signed \_\_\_\_\_

SUPPLEMENTARY

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

PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-14440