

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED OCT 17 1941

Registration District No. 277

Primary Registration District No. 5610

1. PLACE OF DEATH:

(a) County: Laclede
(b) City or town: Rolland Magnificent Twp Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: _____
(Specify whether)
In this community: 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: Laclede
(c) City or town: Rural Magnificent Twp
(If outside city or town limits, write "RURAL")
(d) Street No.: _____
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME

Hattie O Harrison

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: Female

5. Color or race: W

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

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

6. (b) Name of husband or wife: C.R. Harrison

7. Birth date of deceased: June 12 - 1885
(Month) (Day) (Year)

8. AGE:

Years: 36 Months: 2 Days: 18

If less than one day: _____ hr. _____ min.

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

10. Usual occupation: Housewife

11. Industry or business: at home

MOTHER FATHER

12. Name: George Kohlmeier

13. Birthplace: Germany Prussia
(City, town, or county) (State or foreign country)

14. Maiden name: Antonina

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

16. (a) Informant: C.R. Harrison

(b) Address: Richland, Mo

17. (a) burial (b) Date thereof: 9-17-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Richland, Mo

18. (a) Signature of funeral director: R.K. Taylor

(b) Address: Richland, Mo

19. (a) Sept 17-41 (b) C.E. Costner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept day: 14
year: 1941 hour: 3:30 minute: 0 P. 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: accidental drowning
Asphyxy
Due to: 3
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): accidental
(b) Date of occurrence: 9-17-41
(c) Where did injury occur?: Lacumade River
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 3

While at work? _____ (Specify type of place) (c) Means of injury: 3
23. Signature: James D. Stanton (M. D. or other)
Address: Lebanon, Mo Date signed: 9-15-41

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

OCT 11 1941

S-31883 - 1941

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5-31883
State File No. 31885
Registrar's No.

Registration District No. 277 Primary Registration District No. 5610

1. PLACE OF DEATH: Laclede
(a) County Laclede
(b) City or town Mayfield Twp
(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 Hattie V Harrison
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 C. R. Harrison 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased June 26, 1874
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 8 If less than one day 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) (Date received local registrar) (b) (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.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept Day 14 year 1941 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him/her alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
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?
While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature..... (M. D. or other).....
Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-31883