

FILED OCT 25 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31912
Do not use this space. 5-12

1. PLACE OF DEATH

(a) County Lafayette Registration District No. KG 6
(b) Township Wellington Primary Registration District No. 4279 Registered No. 18
(c) City Wellington (d) Street No. 11 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Arthur D. Harrison

(a) Residence, No. 11 St. 11
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mayme Harrison
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 20 1886
7. AGE YEARS 55 MONTHS 5 DAYS 22 If LESS than 1 day,hrs.min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labor
9. Industry or business in which work was done, as saw mill, bank, etc. Labor
10. Date deceased last worked at this occupation (month and year) 1941 11. Total time (years) spent in this occupation 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stafford, Kansas

13. NAME Plumer Harrison

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

15. MAIDEN NAME Eva - unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Kath Harrison Wellington Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Wellington Mo. DATE Oct 14 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Emery Funeral Home Wellington, Mo.

20. FILED 11 19 11 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12 1941

22. I HEREBY CERTIFY, That I attended deceased from Sept. 25 1941 to Oct 17 1941

I last saw him alive on Oct 12 1941 Death is said to have occurred on the date stated above, at.....m. The principal cause of death and related causes of importance were as follows:

Acute myocardial degeneration Date of onset Oct 10, 41
Acute pulmonary edema Oct 12, 41
Coronary thrombosis Sept 25, 41

Name of operation none Date of 9-30
What test confirmed diagnosis physic Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury....., 19..... Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury..... Nature of injury..... 9

24. Was disease or injury in any way related to occupation of deceased? no If so, specify..... (Signed) W. C. Delaney (Address) Wellington, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

3CT 2 4 1941

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MAR 16 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 W Roy Lewis

Licensed Embalmer No. 3079

P. O. Address Wellington Md

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.

STANDARD CERTIFICATE OF DEATH

State File No. 31 912

Registration District No. 466

Primary Registration District No. 4279

Registrar's No.

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Wellington
(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 Mo (b) County Lafayette

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

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Arthur S. Harrison

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25
year 1941 hour _____ minute _____ M.

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

Immediate cause of death _____

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 Apr 20 1886
(Month) (Day) (Year)

8. AGE: Years 55 Months 5 Days 12 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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) Oct 14/41 (b) F. H. Munn
(Date received by registrar) (Registrar's signature)

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

1941

S-31912

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