

No. 2
4-13-40
5-17-39
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35489

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 31 1941

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 287

264
3
4

1. PLACE OF DEATH: Marion
 (a) County Marion
 (b) City or town Hannibal Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Fevering Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 0 (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED: 064
 (a) State Mo (b) County Marion 3
 (c) City or town Hannibal 4
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1325 Lyon St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Jacob Harris
 3. (b) If veteran name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 16
 year 1941 hour 5 minute 30 PM
 21. I hereby certify that I attended the deceased from Oct 1
1941 to Oct 16 1941
 that I last saw him alive on Oct 15 1941
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro
 6. (a) Single, widowed, married, divorced 1
 6. (b) Name of husband or wife Jessie Harris 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: (Month) _____ (Day) 18 (Year) 75

Immediate cause of death No records
 Due to _____
 Due to _____

8. AGE: Years about 66 Months _____ Days _____ If less than one day hr. _____ min. _____

Other conditions (include pregnancy within 3 months of death) 932
 Major findings: Of operations _____
 Of autopsy _____

9. Birthplace Hannibal Mo (City, town, or county) (State or foreign country)
 10. Usual occupation Porter

11. Industry or business _____
 12. Name Hannibal Harris
 13. Birthplace Columbia Mo (City, town, or county) (State or foreign country)
 14. Maiden name Armanda
 15. Birthplace Mo (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Jessie Harris
 (b) Address 1325 Lyon St
 17. (a) (Burial, cremation, or removal) _____ (b) Date thereof (Month), (Day) (Year) _____
 (c) Place: burial or cremation Baptist 10 19 41

While at work? (Specify type of place) (e) Means of injury _____
 23. Signature W. A. M. [unclear] (M.D. or other) 0
 Address Hannibal Mo Date signed Oct 17 1941

18. (a) Signature of funeral director W. E. Roberts
 (b) Address Hannibal Mo
 19. (a) Oct 27 41 (b) W. C. Chalker (Date received local registrar) (Registrar's signature)

1 (Licensed Embalmer's Statement on Reverse Side)

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

HCP

1941

DGT 3 0 1941

140r
ES: 1

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. 2113 working under my personal supervision.

Signed Gene E Roberts
Licensed Embalmer No. 2113
P. O. Address Hannibal Mo

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.

ALCOA
MEMPHIS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35489**

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Marion**
(b) City or town **Hannibal**
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jacob Harris

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

4. Sex **M** 5. Color or race **B** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Jane** 6. (c) Age of husband or wife if alive **63** years

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

8. AGE: Years **64** Months _____ Days _____ If less than one day _____ 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) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-19-1941** (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Dec 18, 1941** (Date received local registrar) (b) **E. M. Lucke** (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____ 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 (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 UPDATING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

1947

S-35489