DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3867

Dr Sarn FILED FEB 27 1942

Registration District No. 6 Primary Registration District No. 6101

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Stoddard

(b) City or town: Rural Mississippi 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 years, months or days)

In this community: 5 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Stoddard 103

(c) City or town: Rural (If outside city or town limits, write "RURAL") 0

(d) Street No.: 4 Miles So. west of Canalou (If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country:

3. (a) PRINT FULL NAME: Will Harris

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: M 0

5. Color or race: W

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

6. (b) Name of husband or wife: Dove Harris

6. (c) Age of husband or wife if alive: 47 years

7. Birth date of deceased: 5 (Month) 17 (Day) 1877 (Year)

8. AGE: Years 64 Months 8 Days 7 If less than one day hr. min.

9. Birthplace: Center Ridge (City, town, or county) / Ark. (State or foreign country)

10. Usual occupation: Farm Labor

11. Industry or business: Farming

FATHER 12. Name: James Harris

FATHER 13. Birthplace: Unknown (City, town, or county) / Ark. (State or foreign country)

MOTHER 14. Maiden name: Alice Loyd

MOTHER 15. Birthplace: Unknown (City, town, or county) / Ark. (State or foreign country)

16. (a) Informant: Mrs Dove Harris

(b) Address: Canalou Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/25/42 (Month) (Day) (Year)

(c) Place: burial or cremation: Matthews Mo.

18. (a) Signature of funeral director: Hunter Allbritten

(b) Address: Sikeston Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 24 year 1942 hour 4 minute a.m.

21. I hereby certify that I attended the deceased from 10-24, 1942 to 1-24, 1942 that I last saw him alive on 10-15, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of stomach

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): H6B

Major findings: Of operations:

Of autopsy:

Duration: 1 year

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? (specify type of place)

While at work? (e) Means of injury:

23. Signature: Jim Lowe (M. D. or other) MA

Address: Morehouse Mo. Date signed: 1-29-42

1129 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 142-148
Date Filed 1-30-42

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

Embalmed, Registered Apprentice No.

working under my personal supervision.

Signed Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sikeston Mo.

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

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

No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3867

Registration District No. 839 Primary Registration District No. 6101 Registrar's No.

1. PLACE OF DEATH:
(a) County: Stoddard
(b) City or town: Rural
(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 years, months or days)
In this community

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: Will Harris
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: May (Month) 17 (Day) 1878 (Year)

8. AGE: Years 64 Months 8 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) March 5 (Date received local registrar) (b) Nora Irons (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 4 year 1942 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	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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY