

No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33853
State File No. _____
Registrar's No. 25

FILED NOV 11 1942
Registration District No. 140

Primary Registration District No. 5547

45
0
0
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: *Howard*
(a) County *Howard*
(b) City or town *Rural Monticello*
(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 *Life*
years, months or days _____

2. USUAL RESIDENCE OF DECEASED: *45*
(a) State *Mo.* (b) County *Howard* *0*
(c) City or town *Rural* *0*
(If outside city or town limits, write "RURAL.")
(d) Street No. *Near Asylum Church Hwy 240*
(If rural, give location) *0*
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME *Burella Frances Harris*

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

4. Sex *Female* 5. Color or race *white* 6. (a) Single, widowed, married, divorced *Single*

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

7. Birth date of deceased *Jan. 20 - 1869*
(Month) (Day) (Year)

8. AGE: Years *73* Months *8* Days *20* If less than one day hr. _____ min. _____

9. Birthplace *Howard Co. Mo*
(City, town, or county) (State or foreign country)

10. Usual occupation *at home*

11. Industry or business _____

MOTHER FATHER { 12. Name *Lenny Harris*

13. Birthplace *Madison Co. Ky*
(City, town, or county) (State or foreign country)

14. Maiden name *Sarah Ann Bayton*

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

16. (a) Informant *Laura E. Fisher*

(b) Address *Columbia, Mo*

17. (a) *Burial* (b) Date thereof *10/11/42*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Asheum Cem.*

18. (a) Signature of funeral director *Q. S. Deen Co.*

(b) Address *New 3rd St. Mo*

19. (a) *10-14-42* (b) *Thomas B. Wilmyer*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct.* day *10* year *1942* hour *7* minute *2* M.

21. I hereby certify that I attended the deceased from *Oct 7*, 19*42* to *Oct 7*, 19*42* that I last saw her alive on *Oct 7*, 19*42* and that death occurred on the date and hour stated above.

Immediate cause of death *apoplexy cerebral hemorrhage*

Due to *Hypertension*

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) *gga*

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 *J. T. Chamberlain* (M. D. or other) _____

Address *New Franklin Mo* Date signed *Oct 10 42*

Duration *4 days*
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

JONES

District Health Officer No. 8,

District File Number -----

Date Filed 11-10-42

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed B. L. Hall

Licensed Embalmer No. 3515

P. O. Address New Franklin, 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.