

S. No. 2
4-5-42
5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 30 1943
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 276

1. PLACE OF DEATH: Jackson

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 15 days
(Specify whether years, months or days)

In this community: 25 YRS.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State: Missouri (b) County: Jackson

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

(d) Street No.: 5220 - 1st St. - Saida
(If rural, give location)

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

If yes, name country: No

3. (a) PRINT FULL NAME: SAMUEL OSCAR HARRIS
Sam Harris

3. (b) If veteran, name war: No

3. (c) Social Security No.: NONE

4. Sex: M 5. Color or race: W

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

6. (b) Name of husband or wife: EMMA

6. (c) Age of husband or wife if alive: 64 years

7. Birth date of deceased: Aug 29, 1874
(Month) (Day) (Year)

8. AGE: Years: 68 Months: 4 Days: 18
If less than one day hr. min.

9. Birthplace: Vernon Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: Carpenter

11. Industry or business: Self

12. Name: John H. Harris

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

14. Maiden name: Unknown

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

16. (a) Informant: Samuel H. Harris

(b) Address: 8825 Indip Ave

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: 1-20-43
(Month) (Day) (Year)

(c) Place: burial or cremation: Green Lawn

18. (a) Signature of funeral director: A. A. Blackman

(b) Address: R. C. Mo

19. (a) 1-19-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Jan. day: 17th
year: 1943 hour: 6 minute: 20 A.M.M.

21. I hereby certify that I attended the deceased from: 1-2-43 to: 1-17-43
that I last saw him alive on: 1-17-43
and that death occurred on the date and hour stated above.

Immediate cause of death: Diabetes mellitus

Due to: 61

Due to:

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

Major findings: Of operations:

Of autopsy: None

Duration

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: Dr. R. Thorne
Address: Ed. Dr. K.C. Gen. Hospital Date signed:

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

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..... *H. Blackman*

Licensed Embalmer No. *3639*

P. O. Address..... *R. C. No*

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.