

FILED DEC 11 1943

Registration District No. _____

Primary Registration District No. **5855**

Registrar's No. **179**

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **mt. Vernon, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Missouri State Sanatorium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **52 days**
In this community **52 days**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pikery**
(c) City or town **Dominishan**
(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 **William Harris**

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

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

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

7. Birth date of deceased **Dec 10 1906**
(Month) (Day) (Year)

8. AGE: Years **36** Months **11** Days **21** If less than one day _____ hr. _____ min.

9. Birthplace **Unknown** (City, town, or county) **Missouri** (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **Wm. Randle Harris**
Birthplace _____ (City, town, or county) _____ (State or foreign country)

4. (a) Maiden name **Minnie M. Carnes**
Birthplace **Farmington, Mo.** (City, town, or county) _____ (State or foreign country)

5. Informant **One Michael Beard**
(a) Address **Mo. State Sanatorium**
(b) Date thereof **11-20-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Dominishan, Mo.**

18. (a) Signature of funeral director **Geo. B. Orr**
(b) Address **Mo. Vernon, Mo.**

19. (a) **11-22-43** (Date received local registrar) (b) **Audley Crawford** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **18** year **1943** hour **11** minute **40 P.** M.

21. I hereby certify that I attended the deceased from **Sept 28**, 19**43**, to **Nov 18**, 19**43** that I last saw **him** alive on **Nov 18**, 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**
Lung Abscess
not tubercular
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **114d**

Major findings: Of operations _____
Of autopsy **Abscess pockets**
throughout left lung

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 **Charles A. Beacher** (M. D. or other) **M.D.**
Address **Mo. Vernon, Mo.** Date signed **11-19-43**

Duration **18th**
Physician _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,

District File Number 1243-1361

Date Filed 12-8-43

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 Geo. B. Owen

Licensed Embalmer No. 946

P. O. Address Wm Vernon 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.