

Registration District No. **333**

Primary Registration District No. **3074**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Sikeston  
(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 7 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Neville W. Harris

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M /  
6. (b) Name of husband or wife D.G. Harris 6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased 9 4 1895  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>2</u>	<u>28</u>	hr. _____ min.

9. Birthplace Portageville Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Frank Warth  
13. Birthplace Ravenwood W.Va.  
(City, town, or county) (State or foreign country)  
14. Maiden name Maggie Richardson  
15. Birthplace Portageville Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant D.G. Harris  
(b) Address Sikeston Mo.  
17. (a) Burial (b) Date thereof 12/5/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Morley Mo.

18. (a) Signature of funeral director H.W. Albritton  
(b) Address Sikeston Mo.  
19. (a) 12/4/43 (b) Louise Largent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott  
(c) City or town Sikeston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 723 Tanner  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 2  
year 1943 hour 9 minute 30 p.M.

21. I hereby certify that I attended the deceased from 12-2 1943 to 12-2 1943  
that I last saw her alive on 12-2 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within month of death) \_\_\_\_\_

Major findings: of pneumonia PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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)  
(c) Means of injury ○  
23. Signature E.H. [unclear] (M. D. or other) \_\_\_\_\_  
Address Sikeston Mo. Date signed 12-4-43

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

RECEIVED

District Health Office No. 2,

District File Number 1243-1520

Date Filed 12-6-43

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.....

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

Signed.....

Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sixston

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.

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Sikeston  
(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)

3. (a) PRINT FULL NAME

Neville W. 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 \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_

Sept - 4  
(Month) (Day) (Year)

8. AGE:

Years 48 Months 2 Days 23 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

Mo.  
(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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_

(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 2  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death pneumonia  
lobar

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)

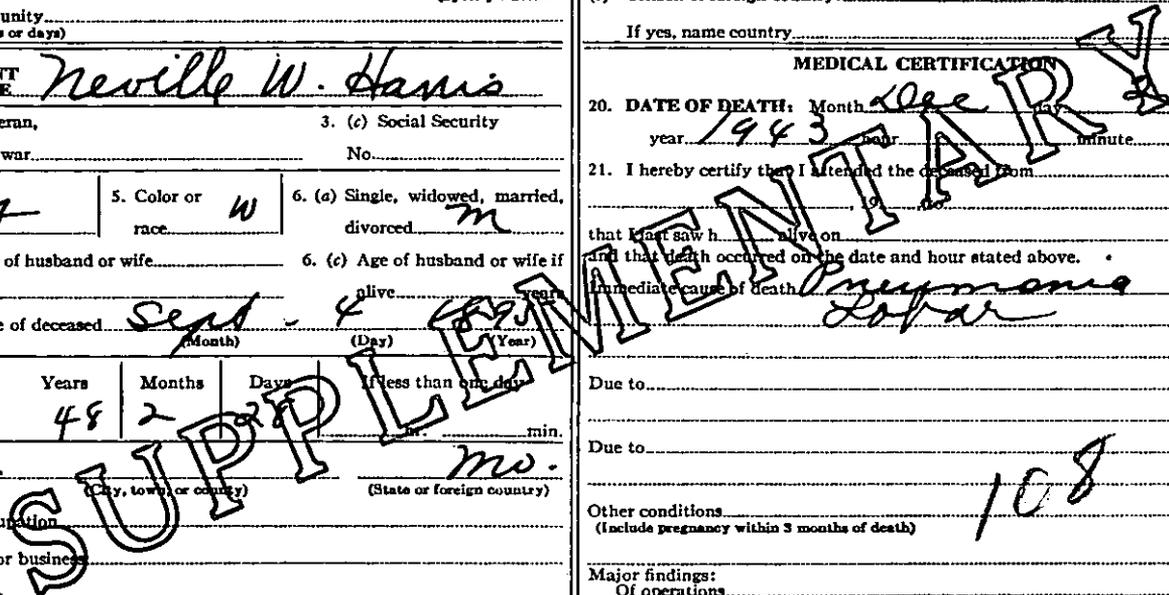
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



108

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