

FILED JAN 12 1944

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 170

1. PLACE OF DEATH:
 (a) County Audrain
 (b) City or town Mexico
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Audrain Hospital 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 13 days
 In this community 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Cynthia E. Harris

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife John Harris

6. (c) Age of husband or wife if alive years
 7. Birth date of deceased September 18, 1858
 (Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days 15 If less than one day hr. min.

9. Birthplace Boone County, Missouri 0
 (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

12. Name William T. Roberts

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

14. Maiden name Elizabeth Dunn 9
 (City, town, or county) (State or foreign country)

15. Birthplace Unknown 9

16. (a) Informant Mrs. O.M. Fleming

(b) Address Burlington, Iowa

17. (a) Burial (b) Date thereof Dec. 4, 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood, Mexico, Mo.

18. (a) Signature of funeral director Earl T. Peck

(b) Address Mexico, Mo.

19. (a) 12/4/43 (b) Margaret H. Mackie
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Audrain 4
 (c) City or town Mexico
 (If outside city or town limits, write "RURAL")
 (d) Street No. 329 S. Missouri Ave.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
 year 1943 hour 5:25 minute AM M.

21. I hereby certify that I attended the deceased from Nov 29 1943, to Dec 3 1943
 that I last saw her alive on Dec 7 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Hypostatic pneumonia
Chronic Myocarditis
 Due to Fistula between Bladder
and Prostate
 Due to Prostatic obstruction
 Other conditions: Arteriosclerosis
 (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Kystoureterostomy performed.
 Of operations performed.
 Of autopsy none

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (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)
 _____ (Specify means of injury)

23. Signature: M. D. or other
Mexico, Mo (M. D. or other)
 Date signed 12/4/43

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

1077

RECEIVED

District Health Officer No. 10

District File Number 1-44-101

Date Filed JAN 11 1944

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.....

Earl E. Precht....., Registered Apprentice No.....

working under my personal supervision.

Signed Earl E. Precht.....

Licensed Embalmer No. 3189.....

P. O. Address Mexico, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. Jan.
 Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
 (a) County Andrian
 (b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Andriana Hosp.
(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)

3. (a) PRINT FULL NAME Cynthia E. Harris
 3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W
 6. (a) Single, widowed, married, divorced, W

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

7. Birth date of deceased: Sept. 8
(Month) (Day) (Year)

8. AGE: 85 2 mo.
Years Months Days If less than one day min.

9. Birthplace _____
(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 27 year 1943 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
 Immediate cause of death: Hypostatic pneumonia
chronic myocarditis
gall bladder & duodenal
duodenal obstruction
 Due to _____
 Due to arteriosclerosis

Other conditions: None
(Include presence within 3 months of death)
 Major findings: operation performed because of duodenal obstruction
 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)
 (c) Means of injury _____
 23. Signature H. Prashar (M. D. or other) MD
 Address Mexico, Mo. Date signed 1/5/44

SUPPLEMENTARY

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

MOTHER FATHER

41479