

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42514
Registrar's No. _____

FILED DEC 17 1943

Registration District No. 112

Primary Registration District No. 112

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Oak Grove
(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 20 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Oak Grove
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Perincia A Harmon

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

4. Sex FM 5. Color or race W 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Wm 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 1 1861 (Month) (Day) (Year)

8. AGE: Years 82 Months 10 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Home wife

12. Name Shelton Grayson

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

14. Maiden name Sarah M. Martin

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

16. (a) Informant David S Grayson

(b) Address Oak Grove Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-43 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Mo

18. (a) Signature of funeral director Wm J Blanks

(b) Address Oak Grove Mo

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14 year 1943 hour 10 minute 0 P. M.

21. I hereby certify that I attended the deceased from 1942 to Nov 14 1943 19____; that I last saw her alive on Nov 14 1943 19____; and that death occurred on the date and hour stated above.

Immediate cause of death floating kidney right, twisted on pedicle Duration 48 hrs

Due to _____
Due to 133 ft 2

Other conditions infarction of oblique (Include pregnancy within 5 months of death) 10 yrs

Major findings: Of operations none Of autopsy none 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 Wm J Blanks (M. D. or other) _____
Address Oak Grove Mo Date signed _____

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

MOTHER FATHER

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.....

R B Webb

Licensed Embalmer No.....

2353

P. O. Address.....

Blosspring Md.

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. 152

Primary Registration District No. 4241

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Oak Grove
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Permiea A. Harman

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

4. Sex F 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 _____ (Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ Unless than one day _____ min.

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

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 1, 1943 (b) Mrs. Jessie M. Histon
(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 Jan 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 _____

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

SUPPLEMENTARY

5-42514