

FILED JAN 31 1943  
Registration District No. **494**

Primary Registration District No. **3008**

Registrar's No. **401**

14  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Callaway

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

(c) Name of hospital or institution: State Road # 12  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 30. Four 2 days  
(Specify whether years, months or days)

In this community: \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME: Engene Harris

3. (b) If veteran, name war: DK.

3. (c) Social Security No.: DK.

4. Sex: Male

5. Color or race: 2 negro

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

6. (b) Name of husband or wife: \_\_\_\_\_

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

7. Birth date of deceased: not given  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>5-5-9</u>			hr. _____ min.

9. Birthplace: no  
(City, town, or county) (State or foreign country)

10. Usual occupation: laborer

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

MOTHER FATHER { 12. Name: not given

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

14. Maiden name: not given

15. Birthplace: DK 9  
(City, town, or county) (State or foreign country)

16. (a) Informant: her cond

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

17. (a) Removal (b) Date thereof: 12 4 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Columbia Mo

18. (a) Signature of funeral director: J. O. Roberts  
(City, town, or county) (State or foreign country)

(b) Address: Columbia Mo

19. (a) 12-4-1943 (b) Joan M. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Peru

(c) City or town: Camdenville  
(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: 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 10 year: 1943 hour: 8 minute: 05 a.m.

21. I hereby certify that I attended the deceased from: 11-20-42 to: 12-1-43  
that I last saw him alive on: 11-30-42 and that death occurred on the date and hour stated above.

Immediate cause of death: lyphatic meningis encephalitis

Duration: \_\_\_\_\_

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

Due to: 30 lb

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

Major findings: \_\_\_\_\_  
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)

(e) Means of injury: \_\_\_\_\_

23. Signature: T. E. Sherrill (M. D. or other)  
Address: Camdenville Mo Date signed: 12/1/43

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**