No. 2
—2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 27 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3109

Registration District No. 154 | Primary Registration District No. 5575 | Registrar's No. 1

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Rural Washington Twp (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 110 East 80th Terrace (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 21 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: Agency "Rural" (If outside city or town limits, write "RURAL")
(d) Street No.: R.F.D. #1 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: WILLIAM H. HARRIS
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: 2
6. (b) Name of husband or wife: Anna E. Harris
6. (c) Age of husband or wife if alive: 59 years
7. Birth date of deceased: May (Month) 7 (Day) 1879 (Year)
8. AGE: Years 64 | Months 8 | Days ____ | If less than one day ____ hr. ____ min.
9. Birthplace: DeKalb Missouri (City, town, or county) O (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business ____
FATHER
12. Name: Dr. H. B. C. Harris
13. Birthplace: Virginia (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Bettie Daniels
15. Birthplace: Tenn (City, town, or county) (State or foreign country)
16. (a) Informant: L. Gobie Harris
(b) Address: 3009 East 31st K.C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 9 44 (Month) (Day) (Year)
(c) Place: burial or cremation: DeKalb Mo.
18. (a) Signature of funeral director: H. A. Billins
(b) Address: Gower Missouri
19. (a) Jan 10-44 (Date received local registrar) J. W. Linnenkohl Jr. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 6 year 1944 hour 5:45 minute P. M.
21. I hereby certify that I attended the deceased from 12/27/44, 19__ to 1/6/44, 19__; that I last saw him alive on 1/6/44, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis and myocardial degeneration	
Due to: Mitral regurgitation	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Pulmonary edema, Pulmonary fibrosis	
Major findings: Of operations:	
Of autopsy: TJD	

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? (specify type of place)
While at work? (e) Means of injury
23. Signature: Lester Roberts (M.D.)
Address: 326 Wornall Date signed 1/7/44

Dr. Anna Co. Hospital

(Licensed Embalmer's Statement on Reverse Side)

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 H. A. Sullins

Licensed Embalmer No. 1738

P. O. Address Dover 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.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3109

Registration District No. 154 Primary Registration District No. 5573 — Registrar's No. 1

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Rural Washington Twp.
(If inside 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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Wm H. 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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 7 (Day) 1883 (Year)

8. AGE: Years 64 Months 8 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw him 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Lester I. Tevel (M. D. or other) D. O.
Address Date signed

SUPPLEMENTARY