

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 25 1944
Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18049
Registrar's No. 394

Primary Registration District No. 5465

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural, N. Campbell Loop
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Beale Nursing Home, Ruffin
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Approx 5 mos
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian
(c) City or town Keokuk
(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

Jospet K. Harless

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased Jan. 1, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 3 22 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Do not know
13. Birthplace Do not know 9
(City, town, or county) (State or foreign country)
14. Maiden name Do not know
15. Birthplace Do not know 9
(City, town, or county) (State or foreign country)

16. (a) Informant Frances Smith
(b) Address Spa, Missouri

17. (a) Removal (b) Date thereof 5-8-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ava, Mo.

18. (a) Signature of funeral director Clankinghead Funeral Home
(b) Address Ava, Mo.

19. (a) 5-8-44 (b) Dr W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6th day May
year 1944 hour 6:00 minute P. M.

21. I hereby certify that I attended the deceased from 5, 5, 44, 19, to 5, 6, 44, 19;
that I last saw him alive on 5, 6, 44, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, cerebral

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) Ja!

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:

(c) 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 injury) _____
While at work? 6 Means of injury 0

23. Signature Dr. M. D. Handley (M. D. or other) M.D.
Address Springfield, Mo. Date signed 5-7-44

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

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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 W.B. Hutchinson
Licensed Embalmer No. 3431
P. O. Address Oran, 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.

X