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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 8 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20653

Registration District No. 149 — Primary Registration District No. 1002 — Registrar's No. 2620

1. PLACE OF DEATH:

(a) County Jackson,
(b) City or town Kansas City, (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robinson Sanitarium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 3-17-43 (Specify whether In this community 43 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48
(c) City or town Kansas City, (If outside city or town limits, write "RURAL") 3
(d) Street No. 5300 Belleview, (If rural, give location) 8
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x

3. (a) PRINT FULL NAME P. Stephen Harris,
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed, 2
6. (b) Name of husband or wife Joyce Welsh Harris
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased unknown (Month) (Day) (Year)

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

9. Birthplace (City, town, or county) Iowa (State or foreign country)
10. Usual occupation none
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) unknown (State or foreign country) 4
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) unknown (State or foreign country) 4
16. (a) Informant Mrs. Franklyn Murphy,
(b) Address 5300 Belleview, Kansas City, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington Cemetery
18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 6-22-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21st, year 1944 hour 1:22 minute A. M.
21. I hereby certify that I attended the deceased from March 14, 1943, to June 20, 1944; that I last saw him alive on June 20, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia nephritis	48 hours
Due to Generalized arteriosclerosis	10 yrs. or more
Due to	
Other conditions Arterial Hypertension (Include pregnancy within 3 months of death)	
Major findings: Of operations 131 a	
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 B. [illegible] (M. D. ~~or other~~)
Address 1418 Prof. Bldg. K.C., Mo. Date signed 6-21-44

(Licensed Embalmer's Statement on Reverse Side)

Dr. B. Landis Elliott

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 E. M. Plank

Licensed Embalmer No. 1848

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.