

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

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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. _____
Registrar's No. **2687**

FILED JUL 8 1944

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
720 South Wheeling
(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 30 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**

(c) City or town Kansas City, Mo. **3**
(If outside city or town limits, write "RURAL")

(d) Street No. 720 S. Wheeling **8**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William Henry Harrison

3. (b) If veteran, name war No

3. (c) Social Security No. 486-07-5188

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Hattie Harrison 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Aug. 6, 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>10</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation Operator

11. Industry or business K.C. Public Service Co.

12. Name Orra Harrison

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

14. Maiden name Sarah Michial

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

16. (a) Informant Mrs. Marjorie Harrison

(b) Address 720 S Wheeling, K.C. Mo.

17. (a) Burial (b) Date thereof June 30-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buckner, Mo.

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6606 Indep. Awa. K.C. Mo.

19. (a) 6-28-44 (b) D. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
year 1944 hour 8 minute P M.

21. I hereby certify that I attended the deceased from June 2
1944 19. to 6-27- 1944

that I last saw him alive on 6-21 1944

and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of heart Duration _____

Due to Coronary Arteriosclerosis **5 yrs.**

Due to _____

Other conditions 97
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy none

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)

(c) Means of injury _____

23. Signature H. Camery **MD**
(M. D. or other)

Address 6520 Indep. Ave. Date signed 6-28-44

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.