

22137

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 14 1944

Registration District No. 247

Primary Registration District No. 5839

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Franklin Twp - Rural
(If outside 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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Newton
(c) City or town Franklin R. I.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Mickey Harris

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 71 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

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

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

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Benjamin A. Harris

18. Birthplace Newton Co Mo. (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Jennings

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

16. (a) Informant's own signature Benjamin Harris

(b) Address Franklin Mo R I

17. (a) Burial (b) Date thereof 5-30-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newtonia

18. (a) Signature of funeral director Benjamin Harris

(b) Address Franklin Mo R I

19. (a) June 14-44 (b) John Howard (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year 3 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from May 29, 1944, to May 29, 1944 that I last saw her alive on May 29, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Failure Foremen Ovals to Close

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 15 1/2

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 D. E. Rales (M. D. or other) _____

Address Franklin Mo Date signed 6-30-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED July 13
District Health Officer No. _____
District File Number 744-141
Date Filed 7-13-44

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, above space should be left blank.