

FILED AUG 12 1944

3008

Registration District No. 7

Primary Registration District No. 3008

Registrar's No. 92519

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hosp. # 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 m 15 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
(c) City or town Home Lake Tenn
(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 Kate Harris

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

4. Sex Female 5. Color or race col 6. (a) Single-widowed, married, divorced widow

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

7. Birth date of deceased not given
(Month) (Day) (Year)

8. AGE: Years 78 Months 9 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation WTK

11. Industry or business _____

12. Name ATK

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

14. Maiden name _____

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

16. (a) Informant Richard

(b) Address 7-8-44

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-44 (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn

18. (a) Signature of funeral director C. E. Davis

(b) Address _____

19. (a) Date received local registrar's _____ (b) Jovie M. Newkiff (Registrar's signature) _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4 year 1944 hour 8 minute 0 M.

21. I hereby certify that I attended the deceased from 11-19-1943 to 7-4-1944 that I last saw him alive on 7-4- 1944 and that death occurred on the date and hour stated above.

Immediate cause of death change myocardium
Due to arteriosclerosis

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
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) (c) Means of injury _____
Signature Geo. Reuss (M. D. or other) _____
Address Fulton Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

14 1/2

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number.....

Date filed 8-10-44

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 *L. J. Harris, Jr.*

Licensed Embalmer No. *3388*

P. O. Address *A. C. 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.