

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31320**

FILED OCT 9 1944  
Registration District No. **2-10-6**

Primary Registration District No. **3042**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Fredericktown Mo.  
(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 Life years, months or days

3. (a) PRINT FULL NAME

Harrison White

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 4

4. Sex M

5. Color or race W.

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

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

7. Birth date of deceased July 20 1852  
(Month) (Day) (Year)

8. AGE:

Years 92 Months 2 Days 5 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business Self

12. Name Joshua White

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

14. Maiden name Mary Whitworth

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

16. (a) Informant Marvine Bray (nephew)  
(b) Address 1206 Lay Rd. St. Louis, Mo.

17. (a) Burial (b) Date thereof 9/28/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Methodist cemetery Fredericktown, Mo.

18. (a) Signature of funeral director Walter Holt General Manager

(b) Address Fredericktown Mo.

19. (a) Sept 28 1944 (b) S. C. Slangalla  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Madison  
(c) City or town Fredericktown Mo.  
(If outside city or town limits, write "RURAL") 62  
(d) Street No. \_\_\_\_\_ (If rural, give location) 1  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 25  
year 1944 hour 2 minute 4

21. I hereby certify that I attended the deceased from 9/23 to death 9/25 1944  
that I last saw him alive on Sept 25 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure Duration \_\_\_\_\_

Due to age & kidney failure  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy none  
1312

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) no  
(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 M. B. Baskett (M. D. or other) M.D.  
Address Fredericktown Date signed 9/28/44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 1044-4329

Date Filed 10-6-44

**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

*John D. Holt*

Licensed Embalmer No. 4264

P. O. Address

*Fredericktown, 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.**