No. 2
—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 19 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35441

Registration District No. 333 Primary Registration District No. 3074 Registrar's No.

1. PLACE OF DEATH:

(a) County SCOTT

(b) City or town SIKESTON
(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)

(d) Length of stay: In hospital or institution (Specify whether
In this community 5 MONTHS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County SCOTT 100

(c) City or town SIKESTON
(If outside city or town limits, write "RURAL")

(d) Street No. ALABAMA
(If rural, give location)

(e) Citizen of foreign country? (Yes or ~~No~~)

If yes, name country U.S.

3. (a) PRINT FULL NAME JOHN RICHARD HARRINGTON

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race NEGRO

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

6. (b) Name of husband or wife HATTIE LEE

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

7. Birth date of deceased OCT (Month) 11 (Day) 1875 (Year)

8. AGE: Years 69 Months 11 Days 26 If less than one day hr. min.

9. Birthplace MACOMB (City, town, or county) MISS I (State or foreign country)

10. Usual occupation FARMING

11. Industry or business

FATHER
12. Name BOB HARRINGTON
13. Birthplace MACOMB (City, town, or county) MISS. I (State or foreign country)

MOTHER
14. Maiden name NOT KNOWN
15. Birthplace MACOMB (City, town, or county) MISS I (State or foreign country)

16. (a) Informant Mattie Sue Turner

(b) Address P.O. BOX 57 SIKESTON MO.

17. (a) ~~[illegible]~~ CAIRO ILL (Burial, cremation, or removal) (b) Date thereof OCT. 7, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation CAIRO ILL ~~[illegible]~~

18. (a) Signature of funeral director E. S. Donaldson

(b) Address 1907 Walnut St Cairo Ill.

19. (a) 10-11-44 (Date received local registrar) (b) Louis Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 7TH year 1944 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from 10-1-44, 19, to 10-1, 1944; that I last saw him alive on 10-1-44, 19; and that death occurred on the date and hour stated above.

Immediate cause of death cardiac decompensation

Due to

Due to

95C²

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 E. S. Urban (M. D. or other) M-D

Address Sikeston, Mo. Date signed 10-7-44

1318

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1044-1405
Date Filed 10-18-44

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.