No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 16 1945

Registration District No. 84

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4045

State File No. 1664

Registrar's No. 26

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Ashland
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Boone
(c) City or town: Ashland
(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: Calvin Abner Harrison

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Annie Harrison

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

7. Birth date of deceased: Nov. (Month) 30 (Day) 1866 (Year)

8. AGE: Years: 78 Months: 1 Days: 0 If less than one day: hr. min.

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

10. Usual occupation: Farmer

11. Industry or business

MOTHER FATHER
12. Name: Unknown
13. Birthplace: (City, town, or county) (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant: Stine S. Harrison
(b) Address: Ashland, Mo.

17. (a) Burial (Burial, cremation, or removal) **(b)** Date thereof: 1-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation: New Liberty Cemt

18. (a) Signature of funeral director: W. J. Burnett
(b) Address: Ashland Mo

19. (a) Jan. 5, 1945 (Date received by local registrar) **(b)** Mrs. Alice Estes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 30 year: 1944 hour: 6 minute: 55 P.M.

21. I hereby certify that I attended the deceased from Dec 25, 1944 to Dec 30, 1944 that I last saw him alive on Dec 30, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic nephritis — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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: H. B. Fryer (M. D. or other)
Address: Ashland Mo Date signed: 12-30-44

1244

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 1-15-45

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 LeRoy Claypool, Registered Apprentice No. 374, working under my personal supervision.

Signed Wm C. Burnett

Licensed Embalmer No. Ashland M

P. O. Address 3564

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.