

P. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2551**
Registrar's No. **59**

FILED FEB 13 1945

Registration District No. **206**

Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **Jasper**

(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1809 Grand, Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 week 4**
(Specify whether)

In this community **35 years**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** **49**

(c) City or town **Joplin** **2**
(If outside city or town limits, write "RURAL")

(d) Street No. **624 N. Pearl St; Joplin Mo.** **5**
(If rural, give location)

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

If yes, name country **No** **11**

3. (a) PRINT FULL NAME **Bessie Florence Harris**

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

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

6. (b) Name of husband or wife **S.A. Harris** 6. (c) Age of husband or wife if alive **85** years

7. Birth date of deceased **Oct. 10, 1877**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan. 30,** day **1945**
year hour **10-30 P.M.** minute M.

21. I hereby certify that I attended the deceased from **Dec 1** 19**44** to **Jan 27** 19**45**
that I last saw her alive on **Jan 27** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar pneumonia** Duration

8. AGE: Years Months Days If less than one day

67 **3** **21** hr. min.

Due to **108**

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.

9. Birthplace **Clayton Co. Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **John J. Weida**

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

14. Maiden name **Ada C. Johnson**

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

16. (a) Informant (b) Address **624 N. Pearl St. Joplin Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2-3-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Hope Cemetery.**

18. (a) Signature of funeral director **Hurlbut Und. Co.**
(b) Address **Joplin Mo.**

19. (a) **1-31-45** (Date received local registrar) (b) **Gustave S. Sutherlin** (Registrar's signature)

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 **C. C. Coak** (M. D. or other)
Address **Joplin Mo** Date signed **2-1-45**

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

1209

45-1-64

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

Donald L. Blue, Registered Apprentice No. 377

working under my personal supervision.

Signed

Terry K. Hurlbut

Licensed Embalmer No.

959

P. O. Address

Japan Hill

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.