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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 8 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 3705

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 12

**1. PLACE OF DEATH:**

(a) County Saline

(b) City or town Marshall, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fitzgibbons Hospital (If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 3 Days. (Specify whether years, months or days) In this community 25 Years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Saline 97

(c) City or town Marshall (If outside city or town limits, write "RURAL") 1

(d) Street No. 56I West Arrow (If rural, give location) 2

(e) Citizen of foreign country? No. (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME William McKinley Harland

3. (b) If veteran, name war #

3. (c) Social Security No. 487-09-7315

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Hazel Noble

6. (c) Age of husband or wife if alive 4I years

7. Birth date of deceased October 7 1899 ~~1900~~ (Month) (Day) (Year)

8. AGE: Years 45 Months 3 Days 2I If less than one day hr. min.

9. Birthplace Waverly (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation Municiple Utilities

11. Industry or business Water Department

FATHER
12. Name Timothy Wm. Harland
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 1

MOTHER
14. Maiden name Isabelle Galley
15. Birthplace Unknown (City, town, or county) Illinois (State or foreign country) 1

16. (a) Informant Mrs. Wm. K. Harland

(b) Address Marshall, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof I/30/45 (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park Cemetery

18. (a) Signature of funeral director J. Leslie Sweeney

(b) Address Marshall Mo.

19. (a) 1-29-45 (Date received local registrar) (b) Mrs T. Owenthorn (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 28 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from Jan 26, 1945 to Jan 28, 1945 that I last saw him alive on Jan 28, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Shock - Peritonitis

Due to Ruptured Intestine - Illinois

Due to

Other conditions (Include pregnancy within 3 months of death) 186a

Major findings: Of operations 39

Of autopsy yes

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) accident 097

(b) Date of occurrence Jan 26-45

(c) Where did injury occur? at work. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place - (Specify type of place)

While at work? yes (e) Means of injury fall

23. Signature John R Lawrence (M. D. or other)

Address Marshall, Mo. Date signed Jan 28-45

1245

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District No. Number
Date Filed 2-9-45

FEB 20 1945

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 J. Leslie Sweeney

Licensed Embalmer No. 3235

P. O. Address Marshall, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**