S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10773

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: P. O. Box 41 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution -------- (Specify whether
In this community 1 year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott 100

(c) City or town Sikeston 5
(If outside city or town limits, write "RURAL") 2

(d) Street No. P. O. Box 41
(If rural, give location)

(e) Citizen of foreign country? No 11 (Yes or No)

If yes, name country --------

3. (a) PRINT FULL NAME Blanchie Harlan

3. (b) If veteran, name war -------

3. (c) Social Security No. ------

4. Sex Female 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Thomas Harlan

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

7. Birth date of deceased April 28, 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	9	28	..... hr. ..... min.

9. Birthplace Macon, Miss. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business --------

FATHER
12. Name Elijah Doolin
13. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Minerva Williams
15. Birthplace Macon, Mississippi 1
(City, town, or county) (State or foreign country)

16. (a) Informant Teenie Allen
(b) Address P. O. Box 41

17. (a) Burial (b) Date thereof Feb. 26, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Addition Cemetery

18. (a) Signature of funeral director F. J. Sparks
(b) Address Cape Girardeau, Mo.

19. (a) 3/14/45 (b) Laurie Largent
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 25
year 1945 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from 2-18-1945 to 2-24-1945
that I last saw her alive on 2-24-1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar Pneumonia	7 days
Due to Influenza	2 wks.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 33	
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 W. A. Lingal (M. D. or other)
Address 204 S. Locust St. Charleston Mo. Date signed 2-26-45

1318

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 345-46
Date Filed 3/16/45

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 ....., Registered Apprentice No. ....., working under my personal supervision.

Signed Frank Sparks

Licensed Embalmer No. 34555

P. O. Address Cape Girardeau Mo

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.