S. No. 2
M—8-43
7. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17022

State File No.

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 48

1. PLACE OF DEATH:
(a) County: Harrison
(b) City or town: Bethany (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Walker Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 10 days (Specify whether years, months or days)
In this community: 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Harrison
(c) City or town: Bethany (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Rosa Harris
3. (b) If veteran, name war: —
3. (c) Social Security No.
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Sam Harris Dec.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Dec (Month) 1 (Day) 1894 (Year)

8. AGE: Years 50 Months 4 Days 27 If less than one day hr. min.
9. Birthplace: Tazewell (City, town, or county) Virginia (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Don't Know
FATHER 13. Birthplace: Don't Know (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Don't Know
MOTHER 15. Birthplace: Don't Know (City, town, or county) (State or foreign country)
16. (a) Informant: Mary L. Harris
(b) Address: Kansas City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 1, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Yankee Ridge Cemetery
18. (a) Signature of funeral director: Joe E. Wauler
(b) Address: Bethany Mo
19. (a) May 12-1945 (Date received local registrar) (b) Zoa M. Burris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 28 year 1945 hour 2 minute P.M.
21. I hereby certify that I attended the deceased from April 5, 1945, to April 28, 1945, that I last saw her alive on April 28, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis — 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: Ralph L. Walker M.D. or other DO
Address: Bethany, Mo Date signed 5/12/45

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number
Date Filed

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 Joe E. Wheeler

Licensed Embalmer No. 3512

P. O. Address Bethany 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.