

FILED MAY 16 1945

Registration District No. 217

Primary Registration District No. 5786

Registrar's No. 30

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

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston (rural) (Write (If outside city or town limits, write "RURAL" and name of township))

(c) Name of hospital or institution: R#1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Pearl Harris

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

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

4. Sex F 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Eugene Harris 6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased Year of 1906 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>			hr. min.

9. Birthplace Forrest City Ark (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Oscar Chatwell

13. Birthplace N.K. (City, town, or county) (State or foreign country)

14. Maiden name N.K.

15. Birthplace N.K. (City, town, or county) (State or foreign country)

16. (a) Informant Eugene Harris

(b) Address R#1 Charleston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-45 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Charleston Mo.

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) [Signature] (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss.

(c) City or town Charleston (rural) (If outside city or town limits, write "RURAL")

(d) Street No. R#1 (If rural, give location)

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

If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22 year 1945 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from April 16, 1945 to April 21, 1945 and that I last saw her alive on April 21, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Due to Hypertension

Due to

Duration 6 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations [Signature]

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 2

23. Signature [Signature] (M.D. or D.O.)

Address Wyatt, Mo. Date signed 4-23-45

RECEIVED

District Health Office No. 2,

District File Number 275-411

Date Filed 5-11-75

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.

Signature John F. Minnick Jr
Licensed Embalmer No. 3851
P. O. Address Charleston, 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.