

FILED JUL 18 1945 STANDARD CERTIFICATE OF DEATH

State File No. 25244

Registration District No. 381

Primary Registration District No. 4515

Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Milan  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Simpson  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community yes  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carrroll 17  
(c) City or town Hale 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. (If rural, give location) 1  
(e) Citizen of foreign country? (Yes or No)  
If yes name country

3. (a) PRINT FULL NAME Betty Lee Harrison

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

4. Sex Female race Caucasian 5. Color or white 6. (a) Single, widowed, married, divorced single  
7. Birth date of deceased May 31 1919  
(Month) (Day) (Year)

8. AGE: Years 25 Months 7 Days 24 If less than one day  
hr. min.

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

10. Usual occupation House maid

11. Industry or business

12. Name Edward Grant Harrison  
13. Birthplace Linn Co Mo (City, town, or county) (State or foreign country)  
14. Maiden name Harriet Ella Reed  
15. Birthplace Sullivan Mo (City, town, or county) (State or foreign country)

16. (a) Informant Jean Harrison  
(b) Address Hale Mo

17. (a) Burial (b) Date thereof 1-26-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hale

18. (a) Signature of funeral director Peggy Dan  
(b) Address Milan Mo

19. (a) May 45 (b) Mrs L D Green  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1st day 25  
year 1945 hour 2 minute 55 A.M.

21. I hereby certify that I attended the deceased from 1-24, 1945, to 1-25, 1945,  
that I last saw h.e.y. alive on 1-25, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal hemorrhage Duration 12 hrs  
Due to ulcerative colitis

Due to  
Other conditions (include pregnancy within 3 months of death)  
Major findings: 1231 V  
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?

While at work? (Specify type of place) (e) Means of injury  
23. Signature J Simpson (M. D. or )  
Address Milan Date signed 1-25-45

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

5  
1  
0

RECEIVED

District Health Officer No. 10

District File Number 7-45-1183

Date Filed JUL-17-1945

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**