

STANDARD CERTIFICATE OF DEATH

State File No. 27628

FILED AUG 18 1945

Registration District No. 206

Primary Registration District No. 2001

Registrar's No. 343

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1809 Grand Avenue /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... (Specify whether
In this community 20 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town Joplin 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1809 Grand Avenue 5
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William J. Harrison

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

4. Sex male C 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

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

7. Birth date of deceased February 14, 1860 (Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 14 If less than one day hr. min.

9. Birthplace Philadelphia Pennsylvania (City, town, or county) (State or foreign country)

10. Usual occupation retired farmer

11. Industry or business

MOTHER FATHER { 12. Name not known
13. Birthplace not known (City, town, or county) (State or foreign country)
14. Maiden name not known
15. Birthplace not known (City, town, or county) (State or foreign country)

16. (a) Informant Ross Harrison
(b) Address 124 S. 35 St., Omaha, Neb.

17. (a) removal (b) Date thereof 7/30/45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Earlham, Iowa

18. (a) Signature of funeral director PARKER-HUNSAKER

(b) Address 1502 Joplin, Joplin, Mo.

19. (a) 7-30-45 (b) J. C. Coates (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1945 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 1, 1945 to July 28, 1945 that I last saw him alive on July 28, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 1 day
Due to Fractured hip 4 wks

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 122
(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 C. C. Coates (M. D. or other)
Address Joplin, Missouri Date signed 7/20/45

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

45-7-653

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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..... *F M Jones*

Licensed Embalmer No. *2319*

P. O. Address..... *Joplin 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.

Registration District No. 156 Primary Registration District No. 2001

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

3. (a) PRINT FULL NAME Wm J. Harrison
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb. 14 (Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Data received local registrar) (b) _____ (Registrar's signature)

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
of pleuritic, not cerebral
origin
 Due to fracture of hip due to
a fall when he attempted to
get to bath room, fell back
off his bed.

Duration _____

Other conditions _____ (Include pregnancy within 3 months)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations _____

Of autopsy 186

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) no

(b) Date of occurrence _____

(c) Where did injury occur? In the room (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
 While at work? no (Specify type of place) (e) Means of injury accidental

23. Signature G L Coates (M. D. or other) MD

Address Joplin Mo Date signed 8-23-45

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

SUPPLEMENTARY

1948

S-27628