

FILED AUG 18 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 229

Primary Registration District No. 3056

Registrar's No. 141

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Huntsville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Woodland Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 30 minutes
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Huntsville
(If outside city or town limits, write "RURAL")
(d) Street No. Elm Street
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME David Keith Harris

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

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

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

7. Birth date of deceased August 11 1944
(Month) (Day) (Year)

8. AGE: Years 0 Months 10 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Child

11. Industry or business _____

12. Name Samuel David Harris

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

14. Maiden name Arina Sue Howard

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

16. (a) Informant Mrs. Samuel Harris
(b) Address Huntsville, Missouri

17. (a) burial (b) Date thereof 7/3/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huntsville, Missouri

18. (a) Signature of funeral director Tom B. Patton
(b) Address Huntsville, Mo

19. (a) 7-13-45 (b) Arina Sue Howard
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1945 hour 11:05 P.M. minute _____ M.

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

Immediate cause of death Food Poisoning Duration 12 Hrs

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations none 177

Of autopsy none 13

22. If death was due to external causes, fill in the following: _____ 88

(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. D. Dwyer (M. D. or other) MD

Address Huntsville, Mo Date signed 7/13/45

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

MOTHER FATHER

41

RECEIVED

District Health Officer No. 10

District File Number 8-45-1292

Date Filed AUG 16 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 *Tom B Patton*

Licensed Embalmer No. 3914

P. O. Address. *Huntsville, Va.*

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. (294)

Primary Registration District No. (8054)

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moherly
(c) Name of hospital or institution: Woodland Hosp
(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 David K. Harris
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 _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) Irma Kavel
(Date received local registrar) (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.

inmediate cause of death _____
Duration _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 _____ (M. D. or other)
Date signed _____

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

SUPPLEMENTARY

S-28248