S. No. 2
0M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

28642

State File No.

Registration District No. 223 Primary Registration District No. 3020 Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 630 Vernon 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 14 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott 102
(c) City or town Sikeston 5
(If outside city or town limits, write "RURAL")
(d) Street No. 630 Vernon 2
(If rural, give location)
(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME HARRIS ALFRED BACH
3. (b) If veteran, name war W. W. I
3. (c) Social Security No.

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ada Beatrice
6. (c) Age of husband or wife if alive 3x years
7. Birth date of deceased Aug 1 (Month) 188x (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
61	—	19	hr. min.

9. Birthplace Morris (City, town, or county) Minn (State or foreign country)
10. Usual occupation Photographer
11. Industry or business
MOTHER FATHER
12. Name William Back
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
14. Maiden name Martha Marshall
15. Birthplace (City, town, or county) Germany (State or foreign country)
16. (a) Informant Mrs H. G. Back
(b) Address Sikeston, Mo.
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 8-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Kennett Mo
18. (a) Signature of funeral director Welsh Funeral Home
(b) Address Sikeston Mo
19. (a) 8/22/45 (Date received local registrar) (b) Lewis Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 20
year 1945 hour 6 minute 20 P. M.
21. I hereby certify that I attended the deceased from August 20 44
3 20, 1945 to 6-20, 1945
that I last saw him alive on 6-20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Angina Pectoris	
Due to Collapse of Coronary Arteries	
Due to Arterio-Sclerosis	
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature Dr B. L. McMullin M.D. (M. D. or other)
Address 227 West Gladys St Date signed 8-21-45

1318

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 9-5-2992
Date Filed 9-5-45

FEB 28 1945

OCT 31 1945

DEC 29 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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.