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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30925

FILED OCT 15 1945

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 122

1. PLACE OF DEATH:

(a) County: Livingston

(b) City or town: Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 430 Cherry Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 1 month 18 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri. (b) County: Livingston 59

(c) City or town: Chillicothe 1
(If outside city or town limits, write "RURAL")

(d) Street No.: 430 Cherry Street 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME: Carol Elaine Harper

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Female

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: July (Month) 19th. (Day) 1945 (Year)

8. AGE: Years 0 | Months 1 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace: Chillicothe, (City, town, or county) Missouri. (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name: John Harper Jr.
13. Birthplace: Locksprings, (City, town, or county) Missouri. (State or foreign country)

MOTHER
14. Maiden name: Mary Killian
15. Birthplace: Blue Mound, (City, town, or county) Missouri. (State or foreign country)

16. (a) Informant: John Harper Jr.
(b) Address: Chillicothe, Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9- 8- '45 (Month) (Day) (Year)
(c) Place: burial or cremation: Pleasant Ridge Cemetery

18. (a) Signature of funeral director: Norman Funeral Home
(b) Address: Chillicothe, Missouri.

19. (a) ..... (Date received by local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept. day: 7th. year: 1945 hour: 6:00 minute: P. M.

21. I hereby certify that I attended the deceased from Sept. 3, 1945, to Sept 7, 1945, that I last saw him alive on Sept 7, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Gastro-enteritis — Duration: 4 days

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death): N

Major findings:
Of operations: None
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: R. Collier (M. D. or other)
Address: Chillicothe Mo Date signed: 9/8/45

1514 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

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

Frank L. Smiley, Registered Apprentice No.

working under my personal supervision.

Signed Frank L. Smiley

Licensed Embalmer No. 4770

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-3-45
I X43880

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STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 122

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(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 years, months or days)
In this community .....

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 .....

3. (a) PRINT FULL NAME Carol Elaine Harper

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

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

4. Sex Female

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 ..... (Month) ..... (Day) ..... (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) Sept 8, 1945 (Date received local registrar) (b) Frances B. Neill (Registrar's signature)

MEDICAL CERTIFICATION

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

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

	Duration
Immediate cause of death	
Due to	
Due to	
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

30925