

FILED NOV 30 1945

Registration District No. _____ Primary Registration District No. 3000 Registrar's No. 22

1. PLACE OF DEATH

(a) County Adair
 (b) City or town Herkersville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Stickleville 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Laura Harris

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

4. Sex F 5. Color or race W 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: 2 17 1878
(Month) (Day) (Year)

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

67 7 29 hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business

12. Name George Harris
 13. Birthplace Mo
(City, town, or county) (State or foreign country)
 14. Maiden name Evelina Maize
 15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Lura King
 (b) Address Green City, Mo.

17. (a) Burial (b) Date thereof: 10-17-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Pickersell Cemetery

18. (a) Signature of funeral director Thurs E. Kenton
 (b) Address Green City, Mo.
 19. (a) 10-18-45 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16
 year 45 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from Oct 7, 1945 to Oct 16, 1945
 and that death occurred on the date and hour stated above.
 that I last saw her alive on Oct 4, 1945

Immediate cause of death myocarditis
 Due to Fracture Femur / 1 wk.
 Due to _____

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) _____
 (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)

23. Signature Rostreplen (M. D. or other) MD
 Address Krebsville Mo Date signed 10-16-45

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

1614

RECEIVED

District Health Officer No. 10

District No. Number 11-45-1805

Date Filed NOV 27 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 Archibald Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36473

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stickler 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 life
years, months or days

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 Laura Harris

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased 2 (Month) 1929 (Day) (Year)

8. AGE: Years 67 Months 29 Day _____ 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 FATHER { 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) _____ (Registrar's signature)
(Date received local registrar)

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 him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Fell, while walking in front yard + fracture of left hip
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(c) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence Oct. 7-1945
(c) Where did injury occur? Green City, Sullivan Co. Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? farm home
While at work? no (Specify type of place) (e) Means of injury Fell

23. Signature R. Stickler (M. D. or other) MD
Address Kirksville Mo Date signed 11-2-45

SUPPLEMENTARY

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

