DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42171

FILED JAN 25 1946

Registration District No. 282 Primary Registration District No. 3055 Registrar's No. 46

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

1. PLACE OF DEATH:

(a) County Polk

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

(c) Name of hospital or institution: East Walnut 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 80 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Polk 84

(c) City or town Bolivar Mo (If outside city or town limits, write "RURAL")

(d) Street No. East Walnut St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country None

3. (a) PRINT FULL NAME Mary Elizabeth Harris

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F 1

5. Color or race Wh.

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Rance Harris

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

7. Birth date of deceased Aug (Month) 5 (Day) 1859 (Year)

8. AGE: Years 86 Months 4 Days 4 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

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

MOTHER
14. Maiden name Fredrick Rister
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs. Ellis Utterback

(b) Address Bolivar Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Slagle Cemetery

18. (a) Signature of funeral director Erwin & Blue

(b) Address Bolivar Mo

19. (a) Dec 19. 1945 (Date received local registrar) (b) Ralph Gordon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9th year 1945 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from Nov 15, 1945, to Dec 9, 1945; that I last saw her alive on Dec 7 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia	4 days
Due to Fracture left femur	3 wks
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 84

(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 D G McGraw (M. D. or ~~other~~)

Address Bolivar Date signed

1533 (Licensed Embalmer's Statement on Reverse Side)

Page No. 7

12-45-1246

Date Filed 1-3-46

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 Willard P. Erwin

Licensed Embalmer No. 3092

P. O. Address Kahoka, 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.

. S. No. 2B
25M—3-45
1 X43880

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.

Registration District No. 282 Primary Registration District No. 3054 Registrar's No. 46

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Baldwin
(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 80 yr
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 Mary Elizabeth Harris

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex F

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 Aug (Month) 5 (Day) 1859 (Year)

8. AGE: Years 96 Months 4 Days 4 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec Day 9
year 1945 hour minute M.

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

Immediate cause of death

Due to Fall in home

Due to about 10 days before death

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 186 w's
Of autopsy 18

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 D G McCraw (M.D. or other)

Address Date signed

42171