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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8170

Registration District No. 322 Primary Registration District No. 4472 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Miami
(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 Home (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Saline 97
(c) City or town Miami 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Harriet V. Lackson
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 Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 13 (Day) 1859 (Year)

8. AGE: Years 87 Months 1 Days 4 If less than one day hr. min.

9. Birthplace Pendleton Ky (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Charles L. Parkhurst
13. Birthplace New York (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth P. Smith
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant G. M. Lucas
(b) Address Miami, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 28 1946 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director Campbell-Lucas
(b) Address Marshall - Mo
19. (a) 2-25-46 (Date received local registrar) (b) Mrs Earl C Metz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17 year 1946 hour minute 11 P. M.
21. I hereby certify that I attended the deceased from 7-12 1945 to 2-17 1946 that I last saw her alive on 2-17 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia — Duration 1 day
Due to Chronic nephritis — Probably 1 year
Due to
Other conditions Fractured [redacted]
(Include pregnancy within 3 months of death)
Left Hip by fall at home 7-12-45
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)
While at work? (e) Means of injury

23. Signature O. H. Sullivan (M. D. or other)
Address Miami, Mo. Date signed 2-18-46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 3-5-46

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 Jas. H. Penn

Licensed Embalmer No. 1171

P. O. Address Marshall, 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.

No. 2B
I—3-45
P1 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. Mar

Registration District No. 322 Primary Registration District No. 4472 Registrar's No.

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Miami
(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 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 Harriet V. Jackson

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 wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 13 (Day) 1858 (Year)

8. AGE: Years 87 Months 6 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Charles L. Parkhurst
13. Birthplace New York (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth P. Smith
15. Birthplace (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant George Jackson
(b) Address Miami, Mo.

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) Mrs. Earl C. Metz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17
year 1946 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

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation

Of autopsy

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) not due to external causes

(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 R. H. Sullivan (M. D. or other) M.D.

Address Miami, Mo. Date signed 3/21-46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

8170