

STANDARD CERTIFICATE OF DEATH

FILED APR 29 1946

Registration District No. 1

Primary Registration District No. 3000-5000

Registrar's No. 126

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirksville, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: R. F. D. #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 Live
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair
 (c) City or town Kirksville
(If outside city or town limits, write "RURAL")
 (d) Street No. R. F. D. #1
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Billie Merle Harris

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

4. Sex M 5. Color W 6. (a) Single, widowed, married, divorced Single
race

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

7. Birth date of deceased Jan. 26 1931
(Month) (Day) (Year)

8. AGE: Years 15 Months 2 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Jr. High Student

11. Industry or business _____

12. Name Ira Harris

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

14. Maiden name Neoma Dixon

15. Birthplace Putman Co., Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Ira Harris

(b) Address Kirksville, Mo.

17. (a) Burial (b) Date thereof 4/22/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park Cmt.

18. (a) Signature of funeral director D. E. Riley

(b) Address Kirksville Mo

19. (a) 4-24-46 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1946 hour 1 minute 07 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 icked in stomach by male, lived about 30 min. Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 1986/19

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) accident

(b) Date of occurrence Apr. 20 1946

(c) Where did injury occur? at Home 3 mi. S. Kirksville
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at Home

While at work? _____ (Specify type of place) (c) Means of injury 2

23. Signature Foster R. Enley (M. D. or other) Coroner

Address Boonville, Mo Date signed 4-20-46

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

MOTHER FATHER

4-46-1946

4-25-1946

APR

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.....

D. C. Riley

Licensed Embalmer No. *#181*

P. O. Address.....

Kentville, 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. man
Registrar's No. 1260

Registration District No. 1 Primary Registration District No. 5006

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Rural Kitchville
(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

3. (a) PRINT FULL NAME Billie M. Harris

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

4. Sex m 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 _____ year

7. Birth date of deceased Jan 26 (Month) (Day) (Year)

8. AGE: Years 15 Months 2 Days _____ If less than one day _____ hr. _____ min.

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

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) 4-24-46 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month April 20
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her 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 _____

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) _____

(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

12082