

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36606

State File No. ....

Registration District No. 111

Primary Registration District No. 5426

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Villa Ridge  
 (b) City or town Franklin County  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Route 1, Villa Ridge, Mo.  
(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 Ella K. Harris

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John J. Harris 6. (c) Age of husband or wife if alive years

7. Birth date of deceased November 3, 1885  
(Month) (Day) (Year)

8. AGE: Years 61 Months 0 Days 24 If less than one day  
hr. min.

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

10. Usual occupation None

11. Industry or business

12. Name William Freund

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

14. Maiden name Ratherine Kling

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Larry Harris

(b) Address 3805a McDonald

17. (a) Burial (b) Date thereof 11-29-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Southern Funeral Home

18. (a) Signature of funeral director 6322 S. Grand Blvd.

(b) Address 6322 S. Grand Blvd.

19. (a) 12-20-46 (b) May B. Gresh  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36  
 (c) City or town Villa Ridge 0  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Route 1, Villa Ridge, Mo. 0  
(If rural, give location)  
 (e) Citizen of foreign country?.....(Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27<sup>th</sup>  
 year 1946 hour 1 minute 53 A.M.

21. I hereby certify that I attended the deceased from 11-1, 1946, to 11-27, 1946  
 that I last saw her alive on 11-20, 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Carcinoma of Ovary 3 yrs  
 Due to.....

Due to.....  
 Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....  
49A  
 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) (b) Means of injury

23. Signature B. J. Stuhman (M. D. or other) M.D.  
 Address Union, Mo. Date signed 11-27-46

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

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Date Filed 12-19-46  
District File Number.....

District Health Officer No. 9,  
**RECEIVED**

DEC 18 1946

**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 J. W. Bentley

Licensed Embalmer No. 3657

P. O. Address St Louis 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. Dee  
Registrar's No. 57

Registration District No. 111

Primary Registration District No. 5426

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Wells Ridge  
(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

3. (a) PRINT FULL NAME Ella K. 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 m

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

7. Birth date of deceased mn. (Month) 3 (Day) 1946 (Year)

8. AGE: Years 61 Months 6 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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. (c) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) Dec. 20 1946 (b) Mary B. Good (c) \_\_\_\_\_  
(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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, and that death occurred on the date and hour stated above, in immediate cause of death \_\_\_\_\_

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:  
(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 \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

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