

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 11 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36657

State File No. _____
Registrar's No. 923

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1927 N. Benton
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community App: 5mths years, months or days)

3. (a) PRINT FULL NAME WM. ERVIN HARRISON
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mayme Harrison 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 1, 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 11 15 hr. min.

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

10. Usual occupation Ret'd merchant

11. Industry or business _____

12. Name John S. Harrison
13. Birthplace ? Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Fannie Loafman
15. Birthplace ? Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mayme Harrison
(b) Address 1927 N. Benton Springfield, Mo.

17. (a) Burial & removal (b) Date thereof ?
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation TIFFIN, MISSOURI

18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL HOME
(b) Address Springfield, Missouri

19. (a) 11-18-46 (b) W E Huddy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1927 N. Benton
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 16
year 1946 hour 12 A.M minute _____ M.
21. I hereby certify that I attended the deceased from November 9,
1946 to November 16, 1946
that I last saw him alive on November 15, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 wk

Due to arterial hypertension 15 yrs

Due to hypertensive cardiovascular disease 20 yrs

Other conditions (Include pregnancy within 3 months of death)
chronic glomerular nephritis PHYSICIAN _____

Major findings:
Of operations _____
Of autopsy 1318
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? 21

While at work (Specify type of place) (e) Means of injury _____
23. Signature Melvin Kampion (M. D. or other) MD
Address Springfield, Mo Date signed 11-16-46

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

35479

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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.....

Licensed Embalmer No. *L. A. Roaf*
3044

P. O. Address..... **Springfield, Missouri**

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.