

S. No. 2
M-8-43
7-5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37519

FILED NOV 12, 1946

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Johnson

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

(c) Name of hospital or institution:
517 Water St 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none
(Specify whether years, months or days)

In this community 5 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson 51

(c) City or town Warrensburg, Mo. 2
(If outside city or town limits, write "RURAL")

(d) Street No. 517 1/2 Water Street 2
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country None

3. (a) PRINT FULL NAME Georgie Marie Harrison

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 1
year 1946 hour 10 minute 30 P.M.

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased May 25 1946
(Month) (Day) (Year)

Immediate cause of death Purpura unexplained 4-5d
? dietary deficiency

Duration _____

Due to _____

Due to _____

8. AGE: Years _____ Months 5 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Warrensburg Mo. 11
(City, town, or county) (State or foreign country)

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

Major findings: Of operations 200A

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Benjamin Harrison

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

14. Maiden name Viola Morgan

15. Birthplace Maynew Mo. 3
(City, town, or county) (State or foreign country)

16. (a) Informant Lafayette Harrison
(b) Address 517 Water Street

17. (a) Funeral (b) Date thereof Nov 2-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive

18. (a) Signature of funeral director M. A. Wilcox
(b) Address Warrensburg, Mo.

19. (a) Nov. 2, 1946 (b) Sarah Ann Crutcher
(Date received local registrar) (Registrar's signature)

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 Samuel Harrison (M. D. or other) M.D.
Address Warrensburg, Mo. Date signed 11/2/46

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

36000

147

(Licensed Embalmer's Statement on Reverse Side)

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..... *No Embalming*

Licensed Embalmer No.....

P. O. Address.....

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.