

No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5-831
Registrar's No. 2

FILED JAN 22 1947
Registration District No. 128

Primary Registration District No. 2000

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

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:
913 N. Patton Alley
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 34
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 913 N. Patton Alley 6
(If rural, give location) No 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wallace Pharris
(b) If veteran, name war None
(c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, 2 divorced Widowed
(b) Name of husband or wife No record
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 29 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 4 4 hr. min.

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

10. Usual occupation Retired

11. Industry or business Brick Mason

MOTHER FATHER

12. Name James W. Pharris

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

14. Maiden name Catherine VanBuren Moore

15. Birthplace Brooklyn N.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Wayne Pharris

(b) Address Harbor City, California

17. (a) Burial (b) Date thereof 1/13/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Fred C. Thieme

(b) Address Springfield, Missouri

19. (a) 1/10/47 (b) W.E. Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 3
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
No physician in attendance
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Probably Cerebral Hemorrhage

Due to _____

Due to _____

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

Major findings: Of operations 93A
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? _____

(Specify type of place) _____
(e) Means of injury _____

23. Signature W.E. Handley Local Registrar (M. D. or other) M.D.

Address Springfield, Missouri Date signed 1/20/47

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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..... *Raye H. Thinner*

Licensed Embalmer No. *3681*

P. O. Address. *Springfield, 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. 747
Registrar's No. 5

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:
(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 Wallace Pharris
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 wid
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....
7. Birth date of deceased aug 29
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Ind. (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. (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) January 10, 1947 (b) W. E. Handley M.D.
(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..... Year 1947 Hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... to.....
that I last saw him..... alive on..... 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.....

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.....

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

SUPPLEMENTARY

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

MOTHER FATHER

S-831