

No. 2
-13-40
17-36
23150

FILED APR 7 1947
Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 72

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(c) Name of hospital or institution 1116 Valley St.
(d) Length of stay: In hospital or institution _____
In this community 65 years

3. (a) PRINT FULL NAME ALICE LETHA HARRISON
(b) If veteran, name war none
(c) Social Security No. none

4. Sex female / race white
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
(b) Name of husband or wife William H. Harrison
(c) Age of husband or wife if alive --- years
7. Birth date of deceased October 28 1858

8. AGE: Years 88 Months 4 Days 24
If less than one day -- hr. -- min.

9. Birthplace West Union West Virgin
(City, town, or county) (State or foreign country)

10. Usual occupation retired housewife

11. Industry or business at home

12. Name unknown
13. Birthplace unknown
14. Maiden name unknown
15. Birthplace unknown

16. (a) Informant Mr. Arthur Harrison

(b) Address 1116 Valley St, Carthage, Mo

17. (a) burial (b) Date thereof Mar 25, 1947

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage, Missouri.

19. (a) 3-26-47 (b) L.B. Clinton M.D.

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Carthage
(d) Street No. 1116 Valley St.
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1947 hour 4 minute 05 P.M.

21. I hereby certify that I attended the deceased from 2/21/17 1947 to March 22 1947
that I last saw her alive on March 20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to arteriosclerosis

Due to Senility

Other conditions

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?
(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 L.B. Clinton (M. D. or other)

Address Carthage, Mo. Date signed 3/24/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

139

47-3-267

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.....
Robert W. Knell....., Registered Apprentice No. 406.
working under my personal supervision.

Signed.....Ernest R. Knell.....
Licensed Embalmer No. 391
P. O. Address Carthage

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.

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 72

Registration District No. 157 Primary Registration District No. 3026

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

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(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 Allice J. Harrison

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 and

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

7. Birth date of deceased Oct 2 1901
(Month) (Day) (Year)

8. AGE: Years 88 Months _____ Day _____ If less than one day, hr. _____ min. _____

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-24-47 (b) L. B. Clinton, 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 March 2
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

Due to _____

Due to _____

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

Major findings: 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) _____

(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 _____

S-9621