

S. No. 2
FORM-5-43
Rev. 5-17-39
No. 1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 12 1947
1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13477
Registrar's No. 1937

Registration District No. 199 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County JACONSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1010 PASEO
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 60 YEARS years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON 48
(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1010 PASEO 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MR. FRANK FAUST HARRES
(b) If veteran, name war. No
(c) Social Security No. NONE
(d) Sex MALE (e) Color or race WHITE
(f) (a) Single, widowed, married, divorced SINGLE
(g) (b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
(h) Birth date of deceased JULY 19 1865 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month APRIL day 29TH
year 1947 hour 12 minute 50 P.M.
21. I hereby certify that I attended the deceased from April 28
1947 to _____ 19____
that I last saw him alive on April 28 1947
and that death occurred on the date and hour stated above.

8. AGE: Years 81 Months 9 Days 10 If less than one day _____ hr. _____ min.
9. Birthplace ATCHISON KANSAS (City, town, or county) (State or foreign country)
10. Usual occupation RETIRED

Immediate cause of death Pneumonia, Left Lobar
Due to Sclerosis
Due to _____
Other conditions Paralysis Agitans (m.m.)
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business
12. Name THEODORE C. HARRES
13. Birthplace PHILADELPHIA PENNSYLVANIA (City, town, or county) (State or foreign country)
14. Maiden name REBECCA BEY
15. Birthplace OHIO (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy 108
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. KATHERINE HARRES
(b) Address 1010 PASEO
17. (a) BURIAL (b) Date thereof MAY-1-1947 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT. MORIAH CEMETERY
18. (a) Signature of funeral director D. J. Delacombe
(b) Address 1401 BUSH CREEK BLDG.
19. (a) 4-30-47 (b) Geraldine Holmes (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)
(c) Means of injury 2
23. Signature R.M. Lilley (M. D. or other) DO.
Address 243 W. 13th Bldg. N. Date signed 4-29-47
Kansas City, Mo

244 N. 10th St.
10.6

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..... *Bernard L. Horan*

Licensed Embalmer No. *4250*

P. O. Address..... *140 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.