

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14433

FILED MAY 7 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 4402

Registrar's No. 83

1. PLACE OF DEATH:

(a) County Peru

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

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether)

In this community 50 years
years, months or days

3. (a) PRINT FULL NAME Robert Lee Harris

3. (b) If veteran, no name war _____

3. (c) Social Security No. _____

4. Sex MO

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Emma Harris

6. (c) Age of husband or wife if alive 94 years 1873
(Month) (Day) (Year)

7. Birth date of deceased Aug
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>7</u>	<u>13</u>	hr. _____ min. _____

9. Birthplace Burns MO
(City, town, or county) (State or foreign country)

10. Usual occupation retired

MOTHER FATHER

11. Industry or business _____

12. Name unknown 9

13. Birthplace " 9
(City, town, or county) (State or foreign country)

14. Maiden name unknown 9

15. Birthplace " 9
(City, town, or county) (State or foreign country)

16. (a) Informant Thad R. Keckley

(b) Address Blue Hill St. No. 305

17. (a) Buried (b) Date thereof 2-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ignace

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 5-1-47 (b) S. L. Robinson
(Date received local registrar) (Registrar's signature) 7110

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln 78

(c) City or town Dexter
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) _____

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1947 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from March 10-
1947, to March 19, 1947

that I last saw him alive on March 18, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Duration _____

Due to High Blood Pressure

Due to _____

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

Major findings: Paralysis

Of operations [Signature]

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 [Signature] (M. D. or other) 0

Address Steele Mo Date signed 4-2-47

5-47-144

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 John H. Gorman

Licensed Embalmer No. 4355

P. O. Address Bayti, N.S. Bay

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. *272*

Primary Registration District No. *4402*

Registrar's No. *838*

1. PLACE OF DEATH:

(a) County *Pemiscot*
(b) City or town *Horton*
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME *Robert L. Farris*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color of race *w* 6. (a) Single, widowed, married, divorced *m*

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

7. Birth date of deceased *aug 6*
(Month) (Day) (Year)

8. AGE: Years *73* Months *2* Days *7* If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town or county) (State or foreign country) *mo*

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *[Signature]* (b) *[Signature]*
(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 *May* 19 *47* year. *19* hour. *19* minute. M.

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

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

SUPPLEMENTARY

14433