

S. No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1947
Registration District No. 310

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14719
Registrar's No. 60

Primary Registration District No. 3058

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

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hours
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Charles
(c) City or town O'Fallon
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Samuel L. Harsbarger
3. (b) If veteran, name war no
3. (c) Social Security No. 487-22-253

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 25 year 1947 hour 9 minute 30 P.M.
21. I hereby certify that I attended the deceased from 25 Mar 1947 to 25 Mar 1947
that I last saw him alive on 25 Mar 1947 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased Sep't. 4 1896
(Month) (Day) (Year)

Immediate cause of death generalized lymphosarcoma
Duration 5 yrs.

8. AGE: Years Months Days If less than one day
50 6 21 .hr. min.

Due to hydrothorax, acute
Due to _____

9. Birthplace Centralia Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Mechanic
11. Industry or business _____

Other conditions (Include pregnancy within 3 months of death) 55
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER
12. Name Samuel Harsbarger
13. Birthplace Audrain Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Doling
15. Birthplace Boone Co. Mo.
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Twila Harsbarger
(b) Address O'Fallon Mo.
17. (a) Burial (b) Date thereof 3-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Centralia Mo.
18. (a) Signature of funeral director E. A. Keithley
(b) Address O'Fallon Mo.
19. (a) Apr 8/47 (b) Frank Hamilton
(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 0
23. Signature Lawrence D. Behm (M. D. or other)
Address O'Fallon Mo. Date signed 28 Mar 47

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Date Filed 4-21-47

District File Number

District Health Officer No. 9,

RECEIVED

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 *E. Keethy*

Licensed Embalmer No. 827

P. O. Address *Fuller Ave*

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.