

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 18 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37380

Registration District No. 39

Primary Registration District No. 4097

Registrar's No. 170

1. PLACE OF DEATH:

(a) County Cass  
(b) City or town Harrisonville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Harrisonville Memorial Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community 52 years years, months or days)

3. (a) PRINT FULL NAME

Jasper Lee Archison  
3. (b) If veteran World War I (c) Social Security 494-16-8063  
name was No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M. I  
6. (b) Name of husband or wife Edith 6. (c) Age of husband or wife if alive 44 years  
Belle Lawson (Month) (Day) (Year)  
7. Birth date of deceased Sept 20 - 1895

8. AGE: Years Months Days If less than one day  
52 1 12 hr. min.

9. Birthplace Archie Mo. U  
(City, town, or county) (State or foreign country)

10. Usual occupation interior decorator

11. Industry or business

12. Name James Archison

13. Birthplace Archie Mo. U  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bell

15. Birthplace Ill. U  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Edith Archison

(b) Address Archie Mo.

17. (a) Burial (b) Date thereof 11-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reseant Hill Cemetery

18. (c) Signature of funeral director Edithson

(b) Address Archie Mo.

19. (a) Nov. 12 - 1947 (b) Lama J. Jones  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Cass 19  
(c) City or town Archie Mo. 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. No Number. 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2  
year 1947 hour 6 minute 45 A.  
21. I hereby certify that I attended the deceased from Nov 1st  
1947 to Nov 2, 1947

that I last saw him alive on Nov 1st, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Ca obstruction of bowel perforation Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations HCE

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?

(Specify type of place) While at work? (c) Means of injury 0

23. Signature Harry B. Jones (M.D. or other)

Address Harrisonville, Mo Date signed 11/2 - 47

NOV 26 1984

NOV 20 1984

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, by

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*Floyd Alberson*

Licensed Embalmer No. 3420

P. O. Address

*Harrisonville*

**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.