

No. 2
-1747
-1739

National Office of Vital Statistics

FILED MAR 18 1948

State File No. _____

Registration District No. 24

Primary Registration District No. 6093

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution: Saline County Home - Marshall Twp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

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

(d) Street No. R.R. - Saline County Home
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Will HARRIS

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race Unknown

6. (a) Single, widowed, married _____

6. (b) Name of husband or wife _____

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 25th day
48 year 3 hour 11^{1/2} min. P.M.

21. I hereby certify that I attended the deceased from Feb 24 1948 to Feb 25 1948
that I last saw him on Feb 24 1948 and that death occurred on the date and hour stated above. Duration 48

Immediate cause of death: arterial sclerosis

8. AGE: Years Months Days If less than one day

about 60 hr. min.

Due to _____

Due to _____

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

9. Birthplace U.S.A.
(City, town, or county) (State or foreign country)

10. Usual occupation unknown

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant unknown
(b) Address _____

17. (a) Burial (b) Date thereof 3-1-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation the View

18. (a) Signature of funeral director James L. Smith
(b) Address Marshall Mo.

19. (a) Mar 1-1948 (b) Sidney T. Gray
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings: _____
Of operations: OK

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? _____ (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)

(e) Means of injury _____

23. Signature James L. Smith (M. D. or other) _____
Address Marshall Date signed 2/28/48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-17-48

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 _____

Licensed Embalmer No. 4270

P. O. Address Traverse City

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.

Registration District No. 324

Primary Registration District No. 6093

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(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 Will Harris

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

4. Sex m 5. Color B 6. (a) Single, widowed, married, divorced and

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

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

8. AGE: Years at 60 Months _____ Days _____ (If less than one day, _____ min.)

9. Birthplace Unknown (City, town, or county) U.S.A. (State or foreign country)

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-27-1948 (b) Sidney T. Gray (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 _____

1948 MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 3 year 1948 hour _____ 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 _____

Due to _____

Due to _____

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

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? _____ (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 _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MAR 29 1948

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-11179