

No. 2  
-1/47  
5-17-39

1. PLACE OF DEATH:  
(a) County. McDonald.  
(b) City or town. Noel, Route #2  
(If outside city or town limits, write "RURAL" and name of township) Pineville  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. None. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State. Mo. (b) County. McDonald  
(c) City or town. Noel, Rural.  
(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 John Richard Harris.  
3. (b) If veteran, name war None 3. (c) Social Security No. None.

4. Sex OM 5. Color or race W 6. (a) Single, widowed, married, divorced. W  
6. (b) Name of husband or wife. \_\_\_\_\_ 6. (c) Age of husband or wife if alive 17th years  
7. Birth date of deceased. June 17th 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 10 6 hr. min.

9. Birthplace. \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation. Farmer.

11. Industry or business. Same.

12. Name. B.F. Harris.

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

14. Maiden name. Unknown.

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

16. (a) Informant. Led Gibson

(b) Address. Tulsa Okla 1903 E. Newton

Reg. Mt. Grove, Mo. (c) Date thereof. 4/27th/48.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Mt. Grove, Mo.

18. (a) Signature of funeral director. P. M. Humphrey

(b) Address. Pineville Mo.

19. (a) 5-24-48 (b) Mrs. B.F. Bradley  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23rd  
year 1948 hour 11 minute 30 a.m.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Duration \_\_\_\_\_

Immediate cause of death. Internal External Hemorrhage

Due to \_\_\_\_\_  
Due to Gunshot wound.

Other conditions. (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations. \_\_\_\_\_

Of autopsy. \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence. 4-23-48

(c) Where did injury occur? Noel, McDonald, Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury Gunshot

23. Signature. P. M. Humphrey (Specify type of place)

Address. Pineville Mo Date signed. 4-25-48

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

RECEIVED  
District Health Officer No. 6,  
District File Number 548-629  
Date Filed MAY 26 1948

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 Mayne E. Humphrey  
Licensed Embalmer No. 4262  
P. O. Address Parisville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June 13  
Registrar's No. 13

Registration District No. 185

Primary Registration District No. 5714

1. PLACE OF DEATH  
(a) County McDonald  
(b) City or town Rural  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME John R. Harris  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month June Day 23  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m  
5. Color or race w  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

7. Birth date of deceased June 17 1901  
(Day) (Month) (Year)  
8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)

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 \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

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

S-16926