

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

State File No. _____

FILED JUL 17 1948

Registration District No. _____

Primary Registration District No. 3012

Registrar's No. 88

1. PLACE OF DEATH:

(a) County CLAY
 (b) City or town EXCELSIOR SPRINGS
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
103 SOUTH STREET
(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 LIFETIME
years, months or days)

3. (a) PRINT FULL NAME SAMUEL T. HARRIS

3. (b) If veteran, name war NO 3. (c) Social Security No. 492-14-1016

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced DIVORCED

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

7. Birth date of deceased: DECEMBER 10, 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>6</u>	<u>26</u>	hr. _____ min.

9. Birthplace RAY COUNTY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business NONE

12. Name FRANCIS M. HARRIS

13. Birthplace EXCELSIOR SPRINGS MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name SUSAN M. UNGER

15. Birthplace CLAY COUNTY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clea Mueller

(b) Address 514 Benton, Ex. Springs, Mo.

17. (a) BURIAL (b) Date thereof JULY 9, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ENON CEMETERY

18. (a) Signature of funeral director Charles Prichard

(b) Address Excelsior Springs, Mo.

19. (a) 7/9/48 (b) Cardline Hultberg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY 24
 (c) City or town EXCELSIOR SPRINGS 1
(If outside city or town limits, write "RURAL") 0
 (d) Street No. 103 SOUTH STREET
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 6
 year 1948 hour 6:00 minute 0 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw _____ alive on _____, 19____, and _____ death occurred on the date and hour stated above.

Immediate cause of death Acute Alcoholism 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) Acute Alcoholism

(b) Date of occurrence 7-6-48

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
103 So. St. Hotel 3
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature P.W. Pracher Coroner (M. D. or other)

Address Excelsior Springs Mo. Date signed 7-8-48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

7-16-48

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

Amice L. Jarman, Registered Apprentice No. *88*
working under my personal supervision.

Signed

Albert E. White

Licensed Embalmer No. *4168*

P. O. Address

Excelsior Springs

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.