

No. 2  
-1/47  
17-39

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27112**

**FILED SEP 1 1948**  
Registration District No. **240**

Primary Registration District No. **5827**

Registrar's No. **814**

1. PLACE OF DEATH:

(a) County **New Madrid**  
(b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**3 Miles North Of Lilbourn, Mo.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: **17 Years**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3 Miles North Of Lilbourn**  
(If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Carter H. Harris**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**  
6. (b) Name of husband or wife **Ida Harris** 6. (c) Age of husband or wife if alive **67** years  
7. Birth date of deceased **March 1 1875**  
(Month) (Day) (Year)

8. AGE: Years **73** Months **5** Days **10** If less than one day hr. min.

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

10. Usual occupation **Farming Above**

11. Industry or business **Above**

MOTHER FATHER

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

14. Maiden name **Mary J. Unknown** 15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Homar Harris**  
(b) Address **Piggott, Ark.**

17. (a) **Burial** (b) Date thereof **8/11/48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kewanee, Mo.**

18. (a) Signature of funeral director **Day Funeral Home**  
(b) Address **Malden, Mo.**

19. (a) **8-17-48** (b) **H. T. Ponder**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **10** year **1948** hour **4** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **July 1** 1948, to **Aug 10** 1948, that I last saw him alive on **Aug 9** 1948, and that death occurred on the date and hour stated above.

Immediate cause of death **hemorrhage of intestines**

Due to

Due to

Other conditions **Heart Dropsy**  
(include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **123**

Duration **4 Days**

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)

(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

23. Signature **E. E. Jones** (M.D. or other)

Address **Lilbourn Mo** Date signed **8-11-48**

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

RECEIVED

District Health Office No. 2,

District File Number 848-1026

Date Filed 8-30-48

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**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.....

P. O. Address.....

**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.