

Registration District No. **32**

Primary Registration District No. **5714**

1. PLACE OF DEATH:

(a) County **Bellinger Rural**
(b) City or town **None**
(c) Name of hospital or institution: **Shell Nursing Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 months**
In this community **5 months** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **ALBERT HARRIS**

3. (b) If veteran, name was **Spanish American** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

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 **88** Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **Wideman**

11. Industry or business _____

MOTHER FATHER

12. Name **Not known**

13. Birthplace **Not known** (City, town, or county) (State or foreign country)

14. Maiden name **Not known**

15. Birthplace **Not known** (City, town, or county) (State or foreign country)

16. (a) Informant **Maury Bond**

(b) Address **Haber, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Sept 8 1948** (Month) (Day) (Year)

(c) Place: burial or cremation **Morgan Memorial Park**

18. (a) Signature of funeral director **Alvin S Morgan**

(b) Address **Advocate, Mo.**

19. (a) **10-8-1948** (Date received local registrar) (b) **Wiley Vandenberg** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Bellinger**
(c) City or town **Palma**
(If outside city or town limits, write "RURAL")
(d) Street No. **Wayne St** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **7** year **1948** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. **1** alive on **Aug 31**, 19**48**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decompensation**
Due to **Cerebral Hemorrhage**

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

Major findings: Of operations _____
Of autopsy **430**

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 **John J. Myers** (M. D. or other) Address **Jupiter, Mo.** Date signed **10/2/48**

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

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

RECEIVED

District Health Officer No. 4

District File Number 1048-120

Date Filed 10-12-48

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.....

Not embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Lloyd S. Morgan

Licensed Embalmer No. *3361*

P. O. Address..... *Advance, N*

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. 32 Primary Registration District No. 5114

1. PLACE OF DEATH:

(a) County Bellinger
(b) City or town Reual
(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

Albert Harris

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

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 _____ years

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

8. AGE: 68 Years Months Days (If less than one day) _____ hr. _____ min.

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

10. Usual occupation Woodsman (sheep)

11. Industry or business Coal-Miner.

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

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 _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

S-28853