

FILED AUG 15 1949

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27578

Registration District No. 267

Primary Registration District No. 3049

Registrar's No. 66

1. PLACE OF DEATH:

(a) County Pemiscot
 (b) City or town Mayfield, Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: W 8

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year (Specify whetherIn this community
years, months or days)3. (a) PRINT FULL NAME JOHN MARION HARRISON3. (b) If veteran, name war X 3. (c) Social Security No. _____4. Sex MALE Color or race WHITE 5. (a) Single, widowed, married, divorced WIDOWED6. (b) Name of husband or wife BELLE HARRISON 6. (c) Age of husband or wife if alive 8 years7. Birth date of deceased JUNE 8 1868
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
85 1 21 hr. min.9. Birthplace JACKSON MO
(City, town, or county) (State or foreign country)10. Usual occupation FARMER (RETIRED)11. Industry or business FARM12. Name UNKNOWN13. Birthplace II
(City, town, or county) (State or foreign country)14. Maiden name UNKNOWN15. Birthplace II
(City, town, or county) (State or foreign country)16. (a) Informant JOHN HARRISON
(b) Address 105 NO. WALNUT, MAYFIELD, MO17. (a) REMOVAL (b) Date thereof 7/30/49
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation PEACH ORCHARD ARK18. (a) Signature of funeral director R. S. Seligman
(b) Address Black's Mortuary, Conway Ark.
19. (a) 7-30-49 (b) John Harrison
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Clay
 (c) City or town Peach Orchard
 (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 July day 7
year 1949 hour 7:10 minute PM21. I hereby certify that I attended the deceased from 21 July 1949 to 27 July 1949
that I last saw him alive on 27 July 1949
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral thrombosis Duration 9 days

Due to _____

Due to _____

Other conditions GEN. ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)Major findings: Of operations 332X

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 E. T. Taylor M.D. (M. D. or other) MD
Address Wagoner, Mo Date signed 29 July 1949

8-49-209

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.....

Roman J Selig Jr.

Licensed Embalmer No.....

P. O. Address.....

*562
Corning, Ark.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.