

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics

FILED SEP 29 1949

Registration District No. 378

Primary Registration District No. 4571

State File No. ....

Registrar's No. 16

1. PLACE OF DEATH  
(a) County Sullivan  
(b) City or town Harris  
(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 1 (Specify whether  
In this community Lifetime years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Sullivan  
(c) City or town Harris  
(If outside city, or town limits, write "RURAL")  
(d) Street No. 1 (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME John Henderson Michael  
3. (b) If veteran, name war 0  
3. (c) Social Security No. none

4. Sex m Color or race w  
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 June 12 1870  
(Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 3  
If less than one day hr. min.

9. Birthplace Farmer (City, town, or county) (State or foreign country)  
10. Usual occupation Mercer County Mo

MOTHER FATHER

11. Industry or business.....  
12. Name Wansor Michael  
13. Birthplace Newtown Mo (City, town, or county) (State or foreign country)  
14. Maiden name Mary James Hall  
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant John Michael  
(b) Address Harris Mo  
17. (a) 1 (b) Date thereof (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation Harris Cemetery  
18. (a) Signature of funeral director.....  
(b) Address Newtown Mo  
19. (a) Sept 29 (b) Arta Caldwell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 18  
year 1949 hour 1100 minute 7 M.

21. I hereby certify that I attended the deceased from 1-1-49  
....., 19....., to 9/18 19.....  
that I last saw him alive on 9/17 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death coronary thrombosis - 3 da  
Due to arteriosclerosis - 10 yrs  
Due to.....  
Other conditions..... (Include pregnancy within 3 months of death)  
4 yrs

Duration  
3 da  
10 yrs  
4 yrs

PHYSICIAN  
Major findings:  
Of operations.....  
Of autopsy.....  
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? (Specify type of place)  
While at work? 2 (e) Means of injury 2  
23. Signature Arta Caldwell (M. D. or other) DO  
Address Harris Mo Date signed 9/19/49

RECEIVED SEP 27 1949  
District Health Officer  
District File Number 9-49  
Date Filed SEP 27 1949

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 F. Howard O'Connell  
Licensed Embalmer No. B 240  
P. O. Address Newton

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.