

1434827

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 10 1944

Registration District No. 157

Primary Registration District No. 4218

Registrar's No. 186

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Wenderson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 107 So Commercial St
(If got in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether)

In this community 70 yr
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry

(c) City or town Wenderson
(If outside city or town limits, write "RURAL")

(d) Street No. 107 So Commercial
(If rural, give location)

(e) Citizen of foreign country? ✓ (Yes or No)

If yes, name country U.S.A.

3. (a) PRINT FULL NAME Robert H. Harbix

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. DATE OF DEATH: Month 10 day 30
year 44 hour 4:00 minute PM M.

21. I hereby certify that I attended the deceased from April 4
1944 to Oct 29 1944

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Marjorie 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased (Month) 2 (Day) 19 (Year) 1867

that I last saw him alive on Oct 29 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis

8. AGE: Years 85 Months 8 Days 1 If less than one day hr. min.

Due to Endocarditis

Due to Bright's disease

Other conditions (Includes pregnancy within 3 months of death) Bright's disease

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

10. Usual occupation Rail Roder

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of autopsy ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

11. Industry or business FATHER

12. Name John Elac Starbitt

13. Birthplace Ky (State or foreign country)

14. Maiden name Elizabeth Bowen

15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant Audis Harbitt
(b) Address Wenderson Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-44
(Month) (Day) (Year)

(c) Place: burial or cremation Lawrence Oak Cem

18. (a) Signature of funeral director Fred Wilkerson
(b) Address Wenderson Mo

19. (a) October 31, 1944 (Date received local registrar) Georgia Kitchener (Registrar's signature)

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) _____ (e) Means of injury _____

23. Signature Fred Wilkerson (M. D. or other) _____
Address Wenderson Mo Date signed 10-30

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

2
2
0

1067

(Licensed Embalmer's Statement on Reverse Side)

144

RECEIVED

District Health Officer No. 7,

District File Number 10-44-1282

Date Filed 11-8-44

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 Fred Wilkinson

Licensed Embalmer No. 2478

P. O. Address Clinton Mo

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. *137* Primary Registration District No. *4214*

1. PLACE OF DEATH:

(a) County *Henry*

(b) City or town *Windsor*
(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 *Robert H. Harbitt*

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 *m*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *Feb 19 1885*
(Month) (Day) (Year)

8. AGE: Years *85* Months *8* Days _____ (If less than one day)

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

10. Usual occupation _____

11. Industry or business _____

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

(c) Place: burial or cremation _____

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

19. (a) _____ (Date received local registrar) (b) _____ (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 _____ Year *1944* Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death *Endocarditis* Duration _____

Due to _____ *1318*

Due to _____

Other conditions *Bright's disease*

Chronic Bright's disease PHYSICIAN _____

Major findings: Of operations _____

Of autopsy _____ 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. Signatory *R. J. ...* (M. D. number) _____ Address _____ Date signed *1-14-44*

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

SUPPLEMENTARY

34327