

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **22959**FILED AUG 10 1948
Registration District No. **7**Primary Registration District No. **3023**
Registrar's No. **148**

1. PLACE OF DEATH:

(a) County **Henry Clinton**
 (b) City or town **Clinton**
 (If outside city or town limits, write "RURAL", and name of township)
 (c) Name of hospital or institution:
349 N Water
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mamie Harris**3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

4. Sex **F** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **single**
 6. (b) Name of husband or wife **—** 6. (c) Age of husband or wife if alive **—** years
 7. Birth date of deceased **2 13 1879**
 (Month) (Day) (Year)

8. AGE: Years **69** Months **5** Days **19** If less than one day hr. min.9. Birthplace **Clinton Mo**
(City, town, or county) (State or foreign country)10. Usual occupation **Housekeeper**

11. Industry or business

12. Name **Calvin Hall**
 13. Birthplace **UNKNOWN**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Jane Harris**
 15. Birthplace **UNKNOWN**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Kenneth Hall**(b) Address **Clinton Mo**17. (a) Burial, cremation, or removal **Burial** (b) Date thereof **8-3-48**
(Month) (Day) (Year)(c) Place: burial or cremation **Clinton Cem (Col)**18. (a) Signature of funeral director **Sickman - Dunning**(b) Address **Clinton Mo**19. (a) **8-4-48** (b) **R R Henry**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Henry**
 (c) City or town **Clinton**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **349 N Water**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **2**
year **1948** hour **10** minute **15** P.M.21. I hereby certify that I attended the deceased from **Aug 2**, 1948, to **Aug 2**, 1948,
that I last saw him alive on **8-28**, 1948,
and that death occurred on the date and hour stated above.Immediate cause of death **apoplexy** Duration **12 hr**Due to **hypertension** **5-71**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **g m ill**

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature **R R Henry** (M. D. or other) **MD**Address **Clinton Mo** Date signed **8-3-48**

RECEIVED

District Health Officer No. 7

District File Number 7-28-912

Date Filed 8-9-13

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. 3509.

P. O. Address Calhoun, 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.