

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

39526

Do not use this space.

DEC 10 1939

1. PLACE OF DEATH

(a) County Cumings Registration District No. 288
 (b) Township Frank Primary Registration District No. 5406
 or Kennett R. 2
 (c) City Kennett R. 2 (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Doyle Wayne Harrell

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE N 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) —
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 27-1938
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 2

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

FATHER 13. NAME James Harrell

14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ark

MOTHER 15. MAIDEN NAME Eula Robinson

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ark

17. INFORMANT James Robinson (ADDRESS) Kennett R. 2

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Ridge DATE Aug 30 1939

19. FUNERAL DIRECTOR (NAME) Lyle and Co (ADDRESS) Kennett Mo

20. FILED 11-30 1939 Philes Dove Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 29 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 14 1939, to Aug 29 1939
 I last saw him alive on Aug 28 1939. Death is said to have occurred on the date stated above, at 8:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Transition (Chronic Ills - Colitis) Date of onset 6-1-39

Other contributory causes of importance: None

Name of operation None Date of _____

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Paul Baldwin M. D.
 (Address) Kennett Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 3,

District File Number 1239-727

Date Filed 12/11/39

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.....

P. O. Address.....

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, above space should be left blank.