

FILED JUN 19 1941

STANDARD CERTIFICATE OF DEATH

State File No. 17703

Registration District No. 956 Primary Registration District No. 5394 Registrar's No.

1. PLACE OF DEATH:
 (a) County DOUGLAS
 (b) City or town RURAL
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Home 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community 35 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County Douglas 35
 (c) City or town RURAL (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME ELIZABETH HARRIMAN FOX
 (b) If veteran, name war
 (c) Social Security No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 3 year 1941 hour 1:30 minute A.M.
 21. I hereby certify that I attended the deceased from 2-15-41 to 6-3-41 that I last saw her alive on 6-3-1941 and that death occurred on the date and hour stated above.

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife DANIEL L. FOX 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased JAN. 11 1899 (Month) (Day) (Year)

Immediate cause of death: Cerebral Embolism Duration 4 days
 Due to Thrombophlebitis and Genl. Arteriosclerosis
 Due to Fracture Rt. Hip Feb. 1941
 Other conditions: (Include pregnancy within 3 months of death)
 Major findings: Of operations
 Of autopsy

8. AGE: Years 82 Months 4 Days 22 If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business

MOTHER FATHER { 12. Name HARRIMAN
 13. Birthplace ENGLAND (City, town, or county) (State or foreign country)
 14. Maiden name HANFORD
 15. Birthplace ENGLAND (City, town, or county) (State or foreign country)

16. (a) Informant HAROLD FOX
 (b) Address WILLOW SPRINGS, MO #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1941 (Month) (Day) (Year)
 (c) Place: burial or cremation Willow Springs City Cemetery

18. (a) Signature of funeral director J.C. Burns
 (b) Address Willow Springs, Mo.
 19. (a) (Date received local registrar) (b) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) 046
 (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 J. Callahan M.D. (M. D. or other) O
 Address Willow Springs Date signed 6/4/41

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

RECEIVED
R. P. ... Health Officer No. 5
District Health Officer No. 5
District File Number
Date Filed

RECEIVED
District Health Officer No. 5
District File Number 6911708
Date Filed 6/1/41

145
69

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.....

Thomas R. Burns, WR, Registered Apprentice No. 251
working under my personal supervision.

Signed J. C. Burns
Licensed Embalmer No. 3379

P. O. Address Willow Springs

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17703

Registration District No. 956

Primary Registration District No. 5394

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Douglas
(b) City or town Clinton, Mo.
(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)

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 _____

3. (a) PRINT FULL NAME Elizabeth Harriman
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month June day 3
year _____ hour _____ minute _____ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____
7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Em Duration 40 days
bolism

8. AGE: Years 82 Months 4 Days 22 If less than one day _____ hr _____ min.

Due to Thrombophlebitis and
Gen'l arterio sclerosis
Due to Fract hip 3 mos
5 mos
Other conditions None
(Include pregnancy within 3 months of death)

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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)

Major findings: None
Of operations _____
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence Feb 28, 1941
(c) Where did injury occur? Willow Springs, Howell, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home
While at work? yes (e) Means of injury Fall
23. Signature Dr. Callahan M.D. (M. D. or other) _____
Address Willow Springs, Mo. Date signed 7/24/41

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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17703
Registrar's No. 81

Registration District No. 956

Primary Registration District No. 5394

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

1. PLACE OF DEATH:

(a) County Douglas
(b) City or town Clinton T.P.
(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 Elizabeth Harriman Fox
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced and
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 82 Months 4 Days 22 If less than one day _____ hr. _____ min.

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-11-1941 (b) Rebekah White
(Date received local registrar) (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 June day 3
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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 C.T. Callahan (M. D. or other)
Address Willow Springs Date signed _____

SUPPLEMENTARY