

FILED NOV 11 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 3000

Registrar's No. 262

1. PLACE OF DEATH:

(a) County Madison Adair

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

(c) Name of hospital or institution:  
Laughlin Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 weeks  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME SARAH ELLEN HARRISON

3. (b) If veteran, name war V

3. (c) Social Security No. V

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28  
year 1942 hour 7:05 minute \_\_\_\_\_ P.M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife George H. Harrison

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November 10 1853  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 25, 1942 to Sept. 28, 1942  
that I last saw her alive on Sept. 28, 1942  
and that death occurred on the date and hour stated above.

8. AGE: Years 88 Months 10 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Uremia urel  
5.1.28 M.P.

Duration \_\_\_\_\_

9. Birthplace Emden Marion Co. Mo.  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

12. Name John Wm. Watkins

13. Birthplace Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Stephens

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature John Wm. Watkins

(b) Address 46 E 110th Place Chicago Ill.

17. (a) Burial (b) Date thereof 10/30/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany Church

18. (a) Signature of funeral director D. M. Walker

(b) Address Philadelphia Pa

19. (a) 10/9/42 (b) Mrs. J. P. Wagner  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following: 10221

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence Aug 24, 1942

(c) Where did injury occur? Philadelphia Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
At the home

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature D. P. Brown (M. D. or other) D. P.

Address Laughlin Hospital Date signed 10/4/42

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

Rev. 5-17-39  
U.S. GPO

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 importa

RECEIVED

District Health Officer No. 10

District File Number 11-42-2026

Date Filed ~~7-11-42~~

NOV - 9 1942

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 B. M. Allen

Licensed Embalmer No. 2437

P. O. Address Philadelphia 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33046  
Registrar's No. 262

Registration District No. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kennett, 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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 18  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I first saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above

Immediate cause of death uremia & broken hip Duration \_\_\_\_\_

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) accident  
(b) Date of occurrence Aug. 24, 1942  
(c) Where did injury occur? Shelbyville Mo. (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In the home (Specify type of place)  
While at work? no (e) Means of injury fall

23. Signature L. R. Bond, D. O. (M. D. or other)  
Address Lynchburg, Va. Date signed \_\_\_\_\_

Kennett Mo.

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

MOTHER FATHER

3. (a) PRINT FULL NAME Sarah Ellen Harrison

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 10 (Month) (Day) (Year)

8. AGE: Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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)

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)

