

FILED AUG 12 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25878

Registration District No. 27

Primary Registration District No. 3057

State File No. _____

Registrar's No. 48

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Richmond
(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 MAMIE ANN HARRIS
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife James S. Francis 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 9th 1861 (Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Richmond MO, U.S.A. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Aaron H. Courson

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

14. Maiden name Mary Ann Queauebery (City, town, or county) (State or foreign country)

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

16. (a) Informant A. B. Courson
(b) Address Richmond MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-43 (Month) (Day) (Year)
(c) Place: burial or cremation Spring Grove Cem

18. (a) Signature of funeral director [Signature]
(b) Address Richmond MO

19. (a) Aug 7 1943 (Date received local registrar) (b) Mrs. Clara W. Sapp (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 89
(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 27th year 1943 hour 4 pm minute _____ M.
21. I hereby certify that I attended the deceased from Apr 14 to June 27 1943 that I last saw her alive on June 27 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to arterio-sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations [Signature] 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 [Signature] (M. D. or other) _____
Address Richmond MO Date signed 8-7-43

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

MOTHER FATHER

1280

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 8-11-43

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

Albert Mansin

Licensed Embalmer No.

4157

P. O. Address

Richmond

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. AUG 1

Registration District No. 297 Primary Registration District No. 305-7 Registrar's No. 48

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Richmond
(If outside city or town limits, write "RURAL" and 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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Mamie A. Farris

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased June 9 - 1901
(Month) (Day) (Year)

8. AGE: Years _____ 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 _____ (City, town, or county) (State or foreign country)

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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Ray
(c) City or town Richmond, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. So Thornton St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1943 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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

ONE

5-28876