DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 5 1944

Registration District No. 3-22

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3-07

State File No. 15900

Registrar's No. 12

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

1. PLACE OF DEATH:

(a) County: Saline

(b) City or town: rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: none (Specify whether) In this community: all his life (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Saline

(c) City or town: Slater (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: William Burton Harris

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: male

5. Color or race: white

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

6. (b) Name of husband or wife: none

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

7. Birth date of deceased: Sept. (Month) 25 (Day) 1860 (Year)

8. AGE: Years 83 | Months 6 | Days 27 | If less than one day: hr. min.

9. Birthplace: Saline Co. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: farmer

11. Industry or business:

MOTHER FATHER

12. Name: John Harris

13. Birthplace: don't know (City, town, or county) 0 (State or foreign country)

14. Maiden name: Rachel Ferril

15. Birthplace: don't know (City, town, or county) 0 (State or foreign country)

16. (a) Informant: Mrs. Rachel Wood,

(b) Address: R.F.D. Slater, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 4-24-'44 (Month) (Day) (Year)

(c) Place: burial or cremation: Slater, Mo.

18. (a) Signature of funeral director: Hill Brothers

(b) Address: Slater, Mo.

19. (a) Apr 26-44 (Date received local registrar) (b) Mrs. John Geger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22

year 1944 hour 7 minute a M.

21. I hereby certify that I attended the deceased from Apr. 15 1944 to Apr. 22 1944 that I last saw h alive on Apr. 15 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 93 yr 1	
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: E. W. Caldwell (M. D. or other)

Address: Slater Mo. Date signed: 4-23-44

121

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 5-4-47

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 Sam M Hill

Licensed Embalmer No. 1292

P. O. Address Slater Mo

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 2 Primary Registration District No. 1 2 7 Registrar's No. 12

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

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Rural Cambridge Twp
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(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? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Wm Burton Harris

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 Sept (Month) 25 (Day) 1860 (Year)

8. AGE: Years 83 | Months 6 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

15900