

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 54

1. PLACE OF DEATH:

(a) County Henry

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. all life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry

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

(d) Street No. North Water st  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Wm H Harrison

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 Mar

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

7. Birth date of deceased: Aug 24 1875  
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: Henry Co Mo  
(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 Social Security Office  
(b) Address Clinton Mo

17. (a) Burial (b) Date thereof: 3-3-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Englewood Cem

18. (a) Signature of funeral director Conradus + Prop  
(b) Address Clinton Mo

19. (a) March 3, 1945 (Date received local registrar) Soy Ritchie Deputy (Registrar's signature)

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month 3 day 1  
year 1945 hour 4 minute P M.

21. I hereby certify that I attended the deceased from 2-1-1945 to 3-1-1945  
that I last saw him alive on 3-1-1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Disease  
Chronic Valvular Endocarditis

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

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

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

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: None

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? Yes (Specify type of place) \_\_\_\_\_ Means of injury \_\_\_\_\_

Signature E. C. Beeler (M. D. or other) \_\_\_\_\_  
Address Clinton Mo Date signed 3-3-45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12  
1  
2

RECEIVED

District Health Officer No. 7.

District No. 7

3-45-264

Date Filed

4-6-45

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.....

*J. E. Cousins*

Licensed Embalmer No. 1891

P. O. Address. *Clinton 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, fact should be so stated above.