

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Randolph
Township Sugar Creek
Near Mobley (No. _____) St. _____ Ward _____

Registration District No. 735
Primary Registration District No. 5970

File No. 28105
Registered No. 190
St. _____ Ward _____

2. FULL NAME

E. L. Harrison

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 20 - 1916

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
11 1 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Albert Harrison

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Annie Buchanan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT Albert Harrison
(Address) R. P. Mobley

15. FILED 9-22-27 Thos. P. Fleming
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 22nd 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 20th 1927 to Sept 22nd 1927, and that I last saw h. or alive on Sept 22nd 1927, and that death occurred, on the date stated above, at 10.00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
10 Diphtheria

CONTRIBUTORY (SECONDARY) Unknown
(duration) yrs. mos. da. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at place of death

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? culture / examination
(Signed) M. D. Halliburton, M. D.
9-22-27 (Address) Mobley Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sugar Creek near Mobley DATE OF BURIAL 9-22nd 1927

20. UNDERTAKER Mahon and Son ADDRESS Mobley Mo

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 important.

