

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39146
Registrar's No. 157

DEC 18 1940

Registration District No. 508

Primary Registration District No. 3026

1. PLACE OF DEATH:

- (a) County Lexington
(b) City or town Chillicothe Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Chillicothe Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 hrs!
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Beverly Joyce Harke
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Fr 5. Color or race W
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 24 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. 30 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name George Douglas Harke
13. Birthplace Cowgill Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Orpha Jeannett Eay
15. Birthplace Palo Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature George Harke
(b) Address Cowgill Mo.

17. (a) Burial (b) Date thereof Nov 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Cowgill Mo.

18. (a) Signature of funeral director S. H. Reed
(b) Address Cowgill Mo.

19. (a) 11-24-40 (b) H. H. Grace, W. H.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Has No Residence County _____
(c) City or town _____
(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.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24
year 1940 hour 4 minute 45 P. M.
21. I hereby certify that I attended the deceased from Nov 24, 1940, to Nov 24, 1940
that I last saw her alive on Nov 24, 1940
and that death occurred on the date and hour stated above.

- Immediate cause of death Premature birth
Due to Pneumonitis of mother
Due to Perforated appendix in mother
Other conditions 154
(Include pregnancy within 3 months of death)

- Major findings: Perforated appendix 7 inches
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? 9116
(Specify type of place) (e) Means of injury _____

23. Signature Dr. Gerald M. Howell (M. D. or other) _____
Address Chillicothe Mo. Date signed Nov 24 1940

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.