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X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42688**

Registration District No. **384**

Primary Registration District No. **4227**

Registrar's No. _____

1. PLACE OF DEATH: *Howell*

(a) County _____

(b) City or town *West Plains*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *Christa Hogan Hosp.*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *14 hrs.*
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME: *Joseph Bennett Harlin*

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 *married*

6. (b) Name of husband or wife: *Bessie Griffin*

6. (c) Age of husband or wife if alive *59* years

7. Birth date of deceased: *Oct. 18 1908*
(Month) (Day) (Year)

8. AGE: Years *72* Months *2* Days *2* If less than one day _____ hr. _____ min.

9. Birthplace: *Monroe Co. Ky.*
(City, town, or county) (State or foreign country)

10. Usual occupation: *Merchant*

11. Industry or business: *W.P. Grover*

MOTHER FATHER

12. Name: *John Harlin*

13. Birthplace: *Ken.*
(City, town, or county) (State or foreign country)

14. Maiden name: *Mary Courtin*

15. Birthplace: *Ken.*
(City, town, or county) (State or foreign country)

16. (a) Informant: *Mrs. J.E. Harlin*

(b) Address: *Thayer - Mo.*

17. (a) *W. Plains* (b) Date thereof: *12. 22. 40*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: *Burial*

18. (a) Signature of funeral director: *Leo Carr*

(b) Address: *Thayer - Mo.*

19. (a) *12-21-40* (b) *Vida W. SIMONS*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Oregon*

(c) City or town: *Thayer*
(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 *Dec* day *20* year *1940* hour *2* minute *40 P.M.*

21. I hereby certify that I attended the deceased from *Dec 19*, 1940, to *Dec 20*, 1940, that I last saw him alive on *Dec 20*, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: *Cerebral Hemorrhage*

Due to: *Chronic Diabetes Mellitus*

Other conditions (Include pregnancy within 3 months of death): *59*

Major findings: Of, operations _____

Of autopsy _____

Duration _____

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? *3 1/2*

23. Signature: *Vida W. Simons*
(Specify type of place) (b) Means of injury

Address: _____ Date signed: _____

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

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1201 20 451 00

RECEIVED
District Health Officer No. 5,
District File Number 1415
Date Filed _____

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..... *[Handwritten Signature]*
Licensed Embalmer No. 2852

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, fact should be so stated above.