

FILED DEC 15 1947
Registration District No. **818**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 1/2 months**
(Specify whether years, months or days)
In this community **5 1/2 months**

3. (a) PRINT FULL NAME **DORIS LORAIN HARMON**

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex **F** / 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 **March 11, 1927**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 8 14 hr. min.

9. Birthplace **Burlington Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unknown**

11. Industry or business _____

12. Name **Harry W. Harmon**

13. Birthplace **Ottumwa, Iowa**
(City, town, or county) (State or foreign country)

14. Maiden name **Edith Beel**

15. Birthplace **Weaver, Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edith Harmon**

(b) Address **600 S. Gertrude Ave, Burlington, Iowa**

17. (a) **Removal** (b) Date thereof **11-28-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Burlington, Iowa**

18. (a) Signature of funeral director **A. W. McLaughlin**

(b) Address **2301 Lafayette Ave**

19. (a) **NOV 29 1947** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Iowa** (b) County **999**
(c) City or town **Burlington** **13**
(If outside city or town limits, write "RURAL")
(d) Street No. **600 South Gertrude Ave.** **0**
N.R. (If rural, give location) **2**
(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **25th**
year **1947** hour _____ minute **15 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: **2nd degree burns of 95% of body when the auto which she was a passenger in was involved in a collision causing it to burn in around 4:30 P.M. May 3rd 1947 North of Wilson 200.**
Other conditions: **she had winner of some**
(Include pregnancy within 3 months of death)
could not be determined

Major findings:
Of operations _____

Of autopsy: **18 15**

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) **Open Verdict**
Iowa (b) Date of occurrence **May 3 1947**

(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?
At home
(Specify type of place)

While at work? _____ (e) Means of injury **to stove**

23. Signature **Patrick E. Taylor** (M. D. or other) **3**
Address **Deputy Coroner** Date signed _____

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

MOTHER FATHER

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..... *C W Rogers*

Licensed Embalmer No. *3830*

P. O. Address *301 Lafayette*

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.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County St. Louis
 (b) City or town St. Louis
(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

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Delis J. Harman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased March 11
(Month) (Day) (Year)

8. AGE: Years 20 Months _____ Days _____
If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business Unknown

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 _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 immediate cause of death _____

Duration

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?

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

DEC 27 1947

— 2000 2/15 —