

FILED SEP 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29826

State File No.

BIRTH NO. _____ REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 4186 Registrar's No. 37

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| 1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>FRANKLIN</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SULLIVAN</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SULLIVAN</u> | |
| c. LENGTH OF STAY (In this place) <u>8 YEARS</u> | | d. STREET ADDRESS (If rural, give location) <u>216 N. CHURCH</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NORTHSIDE HOSPITAL D</u> | | | |

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|-------------------------------------|--------------------------|-----------------------------|--------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>JAMUEL</u> | b. (Middle) <u>RINGGOLD</u> | c. (Last) <u>HARWOOD</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 22 1949</u> |
|-------------------------------------|--------------------------|-----------------------------|--------------------------|---|

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|-----------------|---------------------------|---|--------------------------------------|---|---|---|
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u> | 8. DATE OF BIRTH <u>OCT. 8, 1867</u> | 9. AGE (In years last birthday) <u>82</u> | IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
|-----------------|---------------------------|---|--------------------------------------|---|---|---|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR M.D.</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICAL</u> | 11. BIRTHPLACE (State or foreign country) <u>NEW YORK NEW YORK</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
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| 13a. FATHER'S NAME <u>THOMAS HARWOOD</u> | 13b. MOTHER'S MAIDEN NAME <u>XODIE ROSS</u> | 14. NAME OF HUSBAND OR WIFE <u>CLARA HARWOOD</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>CLARA HARWOOD</u> ADDRESS <u>SULLIVAN, MO. 216 N. CHURCH</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>years</u> <u>years</u> <u>years</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive heart failure</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>aortic regurgitation</u> DUE TO (c) <u>arterio-sclerosis</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophied Prostate</u> | | ED. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | |

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|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4211</u> |
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| | | |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from Sept 10, 1949 to 9-22-, 1949, that I last saw the deceased alive on 9-22-1949, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

| | | |
|---|---------------------------------|-----------------------------------|
| 23a. SIGNATURE <u>Ch. Prater M.D.</u> (Degree or title) | 23b. ADDRESS <u>Sullivan Mo</u> | 23c. DATE SIGNED <u>9-23-1949</u> |
|---|---------------------------------|-----------------------------------|

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|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>9/26/49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>RESSURECTION</u> | 24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u> |
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| DATE REC'D BY LOCAL REG. <u>9-23-1949</u> | REGISTRAR'S SIGNATURE <u>Ch. Prater</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Eaton</u> ADDRESS <u>Sullivan, Mo.</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

36
4

District File Number _____
District Health Officer No. 9,

RECEIVED
SEP 27 1949

OCT 27 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. 4344

P. O. Address Dept 28 Sullivan 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.