

FILED MAR 3 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5438

BIRTH NO. _____ REG. DIST. NO. 229 PRIMARY REG. DIST. NO. 5809 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Minnesota b. COUNTY Aitkin	
b. CITY OR TOWN Rural, Danville	c. LENGTH OF STAY (single place) fourist	c. CITY OR TOWN Kenyon	8220
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) P.O. Box 183	

3. NAME OF DECEASED (Type or Print)	a. (First) Byron	b. (Middle) Charles	c. (Last) Harp	4. DATE OF DEATH (Month) (Day) (Year) Feb. 14 1951
-------------------------------------	-------------------------	----------------------------	-----------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never M.?	8. DATE OF BIRTH April 9 1927	9. AGE (In years last birthday) 23 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	--------------------------------------	---	-----------------------------------	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Magazine Salesman	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (State or foreign country) Redwing Minn	12. CITIZEN OF WHAT COUNTRY? USA.
--	---	---	--

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
--------------------	---------------------------	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 4f	16. SOCIAL SECURITY NO. 475-28-9929	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
---	--	-----------------------------------	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral and Meningeal Hemorrhage		C.W.L.		7 8 10 6
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fractured skull		6 8 10 6
		DUE TO (c) injuries received in auto-truck collision		
		II. OTHER SIGNIFICANT CONDITIONS - fractured mandible, shock (Traumatic) Conditions contributing to the death but not related to the disease or condition causing death. Compound fracture NOSE		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT (Specify) accident	21b. PLACE OF INJURY (e.g., in or about home, farm, store, street, office, etc.) U.S. Highway 40	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 19 New Florence Montgomery Mo.
---	---	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb. 14-51 7.30	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Car skidded on icy road onto truck
--	---	--

22. I hereby certify that I attended the deceased from **Feb 14**, 19 **51**, to _____, 19____, that I last saw the deceased alive on **Feb. 13**, 19 **51**, and that death occurred at **7.30 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE Clement W. Secrest D.D.S. Coroner	23b. ADDRESS Montgomery City Mo.	23c. DATE SIGNED 2/15/51
---	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Feb 16 1951	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
--	------------------------------	------------------------------------	---

DATE REC'D BY LOCAL REG. 2-15-51	REGISTRAR'S SIGNATURE Jama D. Helms	25. FUNERAL DIRECTOR'S SIGNATURE Curt A. Redwing	ADDRESS 3rd
---	--	---	--------------------

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

0700
3

File No. _____
DISTRICT HEALTH OFFICE No. 4

MAR 2 1951

RECEIVED

JUN 17 1963

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.

Signed _____

Carl A. Davidson

Signed _____
Student Embalmer

Licensed Embalmer No. *4112*

P. O. Address *Lowell, Mass*

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.