

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16145**

FILED MAY 19 1952

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5466** Registrar's No. **453-A**

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE CALIFORNIA b. COUNTY SAN BERNARDINO	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN "RURAL" So. CAMPBELL		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ONTARIO	
c. LENGTH OF STAY (In this place) 5 WEEKS		d. STREET ADDRESS (If rural, give location) 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1009 M^{rs} GEE			
3. NAME OF DECEASED (Type or Print) a. (First) FRED		b. (Middle) (NONE)	
c. (Last) HARRIS		4. DATE OF DEATH (Month) (Day) (Year) MAY 5 1952	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH FEB. 13-1875
9. AGE (In years last birthday) 77		10. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		11. BIRTHPLACE (State or foreign country) SPARTA MISSOURI	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME SAMUEL HARRIS	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE HARRIET CRAIN, BUNCH, HARRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 446-07-2688	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS CUNICE HARRIS, 1009 M^{rs} GEE, SPRINGFIELD, MO			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocardial Disease	
		INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4222	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)			
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 4-4 , 19 52 , to 5-5 , 19 52 , that I last saw the deceased alive on 5-4 , 19 52 , and that death occurred at 2:15 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE Max Kitchell (Degree or title) MD.		23b. ADDRESS Springfield Mo	
23c. DATE SIGNED 5-8-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAY 8-1952	
24c. NAME OF CEMETERY OR CREMATORY OLARK CEMETERY		24d. LOCATION (City, town, or county) (State) OLARK MISSOURI	
DATE REC'D BY LOCAL REG. 5-14-52		REGISTRAR'S SIGNATURE James H. Amos MD	
25. FUNERAL DIRECTOR'S SIGNATURE John Alan Harris		ADDRESS Cleves, Mo.	

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

John Allen Harris

Licensed Embalmer No. 4390

P. O. Address Cleveland, Mo.

Signed.....
Student Embalmer

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.