

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42121

State File No.

FILED JAN 4 1954

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1324

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph 0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1920 Spratt Ave.		d. STREET ADDRESS (If rural, give location) 1920 Spratt Ave. 0	

3. NAME OF DECEASED (Type or Print) a. (First) Ross	b. (Middle) M.	c. (Last) Harrington	4. DATE OF DEATH (Month) (Day) (Year) December 22, 1953
--	----------------	----------------------	--

5. SEX 0 male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH February 15, 1903	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
------------------	---------------------------	--	---------------------------------------	------------------------------------	------------------------	------------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor & builder	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Seligman, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	---	----------------------------------

13a. FATHER'S NAME D. L. Harrington	13b. MOTHER'S MAIDEN NAME Mary C. Babb	14. NAME OF HUSBAND OR WIFE Margie R.
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 500-14-5278	17. INFORMANT'S SIGNATURE OR NAME Mrs. Margie Harrington	ADDRESS 1920 Spratt Ave. St. Joseph, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Decompensation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Valvular Heart disease 20y 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	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) m.	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 Dec 15, 1953, to Dec 22, 1953 that I last saw the deceased alive on Dec 22, 1953 and that death occurred at 7:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. E. Hartsock</u> (Degree or title)	23b. ADDRESS <u>W. C. St Joseph Mo</u>	23c. DATE SIGNED <u>12/24/53</u>
--	--	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 12/24/1953	24c. NAME OF CEMETERY OR CREMATORY Ashland Mausoleum	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
--	----------------------	--	--

DATE REC'D BY LOCAL REG. <u>Dec 28, 1953</u>	REGISTRAR'S SIGNATURE <u>Catherine M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hector Bacon</u> ADDRESS <u>Funeral Home</u>
--	---	--

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

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 Eyene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St Joseph

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.