

FILED JUN 14 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15531  
Registrar's No. 509A

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 509A		
1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Howell</b>				
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>Springfield</b>		c. LENGTH OF STAY (in this place) <b>5 days</b>		c. CITY OR TOWN <b>West Plains</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>1053 Lincoln</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>VIRGIL</b> b. (Middle) <b>F.</b> c. (Last) <b>HARRIS</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 26, 1954</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>March 26, 1899</b>		
9. AGE (In years last birthday) <b>55</b>		if UNDER 1 YEAR Months		if UNDER 24 HRS. Hours		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Flooring Co.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Ozark County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Joseph Harris</b>			13b. MOTHER'S MAIDEN NAME <b>Purdy Thurston</b>			14. NAME OF HUSBAND OR WIFE <b>Flossie Harris</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Flossie Harris, West Plains, Mo</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Electolyte Imbalance</b>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <b>Pyonephrosis, bilateral</b> DUE TO (c) <b>Renal &amp; Ureteral calculi, bilat.</b>  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 weeks</b> <b>23 yrs.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Minute)		
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 <b>April 19, 54</b> to <b>May 19, 54</b> , that I last saw the deceased alive on <b>April 26, 19 54</b> , and that death occurred at <b>8:00a</b> m., from the causes and on the date stated above.								
23a. SIGNATURE (Name or title) <b>W. Johnson, M.D.</b>				23b. ADDRESS <b>Springfield, Missouri</b>		23c. DATE SIGNED <b>May 29, 1954</b>		
24a. BURIAL CREMATION, REMOVAL (Specify)		24b. DATE <b>May 28, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Clear Springs Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Ozark County, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>6-9-54</b>		REGISTRAR'S SIGNATURE <b>Earl Williamson</b>		25. FEDERAL DIRECTOR'S SIGNATURE <b>Roman - Sharp</b> ADDRESS <b>7 Home Lane Springfield, Mo.</b>				

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

FEB 8 1954

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.....  
Signature of Student Embalmer

Signed *Lewis G. Schaefer*.....

Licensed Embalmer No. *3802*.....

P. O. Address *Springfield*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.