

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5539

FILED MAR 3 1955

State File No.
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>201</u>		PRIMARY REG. DIST. NO. <u>5736</u>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>Macon 0610</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Macon</u>			
b. CITY OR TOWN <u>Atlanta Lyda</u>		c. LENGTH OF STAY (in this place) <u>0</u>		c. CITY OR TOWN <u>Atlanta</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Died at Home</u>				e. STREET ADDRESS (If rural, give location) <u>Lyda Township 0610 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Walter</u> b. (Middle) <u>Harrison</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>2 16 1955</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 12 - 1886</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Days <u>5</u>	IF UNDER 4 HRS. Hours <u>4</u>	Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Macon Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ben Harrison</u>			13b. MOTHER'S MAIDEN NAME <u>Adra Hutchison</u>		14. NAME OF HUSBAND OR WIFE <u>Nellie Hamilton</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>486 28-7683</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Nellie Harrison</u>		ADDRESS <u>Atlanta Mo</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>(Phobak's Alcohol)</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>light attaching pleu</u>							
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) _____		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 <u>2-13</u> , 19 <u>55</u> , to <u>2-14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-14</u> , 19 <u>55</u> , and that death occurred at <u>12</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Eugene D. Platt D.O.</u>				23b. ADDRESS <u>Atlanta Mo.</u>		23c. DATE SIGNED <u>2-12-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb 18 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Labor</u>		24d. LOCATION (City, town, or county) (State) <u>Near Atlanta Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Feb 22 - 55</u>		REGISTRAR'S SIGNATURE <u>Mrs O. B. Griffin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. M. Gooding</u>		ADDRESS <u>Atlanta Mo.</u>	

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

RECEIVED 2.26.55
Macon County Health Department
County File No. 2.55.27
Date Filed 3.1.55

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 *H. M. Goodhue*

Licensed Embalmer No. 1757

P. O. Address *Atlanta*

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.