

FILED OCT 8 1956

THE DIVISION OF HEALTH AND STATISTICS
STANDARD CERTIFICATE OF DEATH

State File No. **32821**

BIRTH NO. _____		REG. DIST. NO. <u>324</u>		PRIMARY REG. DIST. NO. <u>3072</u>		Registrar's No. <u>152</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Saline</u>		b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Marshall, Mo.</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Saline</u>	
c. LENGTH OF STAY (In this place) <u>2 Days</u>		c. CITY OR TOWN <u>Marshall</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>268 West Jackson</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) <u>Nora</u>		b. (Middle) <u>Estelle</u>		c. (Last) <u>Harre</u>		6. DATE OF BIRTH <u>Sept. 12-1880</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. AGE (In years last birthday) <u>76</u>		9. MONTHS <u>0</u>		10. DAYS <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Shackelford, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John William Owens</u>		13b. MOTHER'S MAIDEN NAME <u>Susie Groves</u>		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) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Charles Fitzgerald-Marshall, Mo.</u>			
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) <u>Congestive Heart Failure</u>		DUE TO (b) <u>Arteriosclerotic Heart Disease</u>				DUE TO (c)	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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 <u>4200</u>				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 <u>7-2</u> , 19 <u>56</u> , to <u>10-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-2</u> , 19 <u>56</u> , and that death occurred at <u>2:15 pm</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>James A. Reed M.D.</u>				23b. ADDRESS <u>Marshall Mo.</u>		23c. DATE SIGNED <u>10-2-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>10/5/56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park</u>		24d. LOCATION (City, town, or county) (State) <u>Marshall, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Oct 3-56</u>		REGISTRAR'S SIGNATURE <u>Cecil G. Reed</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Lealie Sweeney - Marshall, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

529
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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.....
Licensed Embalmer No. 3235

P. O. Address M. Arabella

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.