

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22918**
Registrar's No. **190**

FILED OCT 2 1956

REG. DIST. NO. **360**

PRIMARY REG. DIST. NO. **3076**

BIRTH NO. _____		REG. DIST. NO. 360		PRIMARY REG. DIST. NO. 3076		Registrar's No. 190	
1. PLACE OF DEATH a. COUNTY Vernon				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Missouri b. COUNTY Vernon			
b. CITY (If outside corporate limits, write RURAL and give town or township) Nevada		c. LENGTH OF STAY (in this place) 6 Hrs.		c. CITY OR TOWN Richards		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 Nevada City Hospital				e. STREET ADDRESS (If rural, give location) State Rd. O. 6 Richards Rd.			
3. NAME OF DECEASED (Type or Print) a. (First) Bertha b. (Middle) _____ c. (Last) Harkrader			4. DATE OF DEATH (Month) (Day) (Year) Sept. 15 1956				
5. SEX F.		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 6 1892	
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) Bronaugh, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Stephen G. Couch			13b. MOTHER'S MAIDEN NAME Harriet Couch		14. NAME OF HUSBAND OR WIFE Edward Harkrader		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 500 01 8441		17. INFORMANT'S SIGNATURE OR NAME D Mrs. Boyd Taylor Richards, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis & hemiplegia, left ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) arteriosclerotic heart disease & atherosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 9 hours unknown unknown
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) Richards (Vernon) Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		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 Nov 22, 1955 , to Sept 15, 1956 , that I last saw the deceased alive on Sept 15, 1956 , and that death occurred at 2:05 pm. , from the causes and on the date stated above.							
23a. SIGNATURE James J. Pascoe M.D. (Degree or title)				23b. ADDRESS Nevada, Mo.		23c. DATE SIGNED Sept 17 56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 18 25 Sept.		24c. NAME OF CEMETERY OR CREMATORY Deerfield, Mo.		24d. LOCATION (City, town, or county) (State) Deerfield, Mo.	
DATE REC'D BY LOCAL REG. 9-28-56		REGISTRAR'S SIGNATURE Arnold E. Ferry		25. FUNERAL DIRECTOR'S SIGNATURE Richard H. Steiner		ADDRESS Nevada, Mo.	

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

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745000

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 *Loyal C. McLeod*

Licensed Embalmer No. *485*

P. O. Address *Greenville, S.C.*

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.