

Health,
Welfare
Public
Service

300
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 5 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **34776**

Registration District No. **809** Primary Registration District No. **3043** Registrar's No. **375**

1. PLACE OF DEATH a. COUNTY Marion			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Hannibal		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital		Length of stay in lb	d. STREET ADDRESS 219 North Seventh		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Joseph William Harbison			4. DATE OF DEATH October 28, 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1956	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours 21 Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX		10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (City and state or country) Hannibal Missouri		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME James E. Harbison			14. MOTHER'S MAIDEN NAME Margaret Knollhoff		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) XX		16. SOCIAL SECURITY NO. XX	17. INFORMANT James E. Harbison Hannibal Missouri		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into adrenal glands DUE TO (b) Anoxia DUE TO (c) CVD Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 day. 1 day.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7710					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from October 27, 1956 to October 28, 1956 and last saw him ^{him} alive on Oct. 28, 1956 Death occurred at 10 A M m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Robert Lanning, M.D. (Degree or title)			22b. ADDRESS Hannibal, Mo		22c. DATE SIGNED 10/29/56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/29/56	23c. NAME OF CEMETERY OR CREMATORY Brand View Burial Park		23d. LOCATION (City, town, or county) Hannibal Missouri (State)
24. FUNERAL DIRECTOR [Signature] ADDRESS Hannibal Missouri		25. DATE RECD. BY LOCAL REG. 10-30-56		26. REGISTRAR'S SIGNATURE [Signature]	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED NOV 2 1956

MARION CO. HEALTH DEPT.

DATE FILED NOV 2 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *H Crawford Smith*
.....

Licensed Embalmer No.....

P. O. Address Hannibal, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.