

FILED FEB 11 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1811

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lexington</b>		Inside Limits Y <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Odessa</b>		Inside Limits 054 <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lexington Hospt.</b>			Length of stay in lb <b>5 Das.</b>		d. STREET ADDRESS <b>South side</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Archie</b> Middle <b>Jackson</b> Last <b>Harlow</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>1957</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 26, 1887</b>		9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Pipeline</b>		11. BIRTHPLACE (City and state or country) <b>Centralia, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George W. Harlow</b>				14. MOTHER'S MAIDEN NAME <b>Wood</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>443-03-9950</b>		17. INFORMANT Address <b>Mrs. A. J. Harlow, Odessa, Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia &amp; Atelectasis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>secondary to Pentonitis caused by hyperated gangrenous appendix</b> DUE TO (c) <b>By hyperated gangrenous appendix</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
PART..II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>5501</b>							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 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 <b>Jan 26-1957</b> to <b>Jan 30-1957</b> and last saw her alive on <b>Jan 29-57</b> Death occurred at <b>8:30 A</b> m on the date stated above; and to the best of my knowledge from the causes stated.									
22a. SIGNATURE (Degree or title) <b>W. W. Martin M.D.</b>				22b. ADDRESS <b>Odessa Mo</b>			22c. DATE SIGNED <b>2-1-57</b>		
23a. BURIAL, CREMATION, OR OTHER DISPOSITION <b>BURIAL (Specify)</b>		23b. DATE <b>Feb. 1, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odessa Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Odessa, Mo.</b>			
24. FUNERAL DIRECTOR <b>Harman Sparks</b> ADDRESS <b>Odessa, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>2-4-57</b>		26. REGISTRAR'S SIGNATURE <b>Wm. E. Eastbrook</b>			

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Disease 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

MEDICAL CERTIFICATION

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 *William T. Spain*

Licensed Embalmer No. 4

P. O. Address @ Des Moines

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.