

FILED MAY 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16374

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 121

S. 300
v. 1-572

1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>KNOX</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FULTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hurdland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSP</u>		d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <u>35 yrs</u>			
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle _____ Last <u>Harris</u>			4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>57</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-99</u>
9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and state or country) <u>Hurdland MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>DAVID HARRIS</u>		13b. MOTHER'S MAIDEN NAME <u>DOVIE BOWMAN</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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 Address <u>State Hospital #1 Fulton, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary lymphoma, malignant</u>			INTERVAL BETWEEN ONSET AND DEATH <u>ca 1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hemothorax; Cardiac decompensation</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>NONE</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> <u>State Hospital #1</u>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>State Hospital #1</u>	
20f. CITY, TOWN, OR LOCATION <u>Edina</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>May 5 1922</u> to <u>May 10 1957</u> and last saw her alive on <u>XXXXXXXXXXXXXXX</u> Death occurred at <u>8:00 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Sam J. Johnson M.D.</u> (Degree or title)		22b. ADDRESS _____	
22c. DATE SIGNED <u>May 11-1957</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>May 11-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edina</u>
23d. LOCATION (City, town, or county) <u>Edina</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Thalace Funeral Home, Fulton, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 11-1957</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Hector R. Masure*

Licensed Embalmer No. *4996*
P. O. Address *Fulton, Mo.*

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.