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FILED JUL 23 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 25191

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 115

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wallace Hosp — Length of stay in 1b 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN Conway — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) no St. address — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First James Middle Everett Last Harris

4. DATE OF DEATH Month July Day 12 Year 1957

5. SEX M

6. COLOR OR RACE White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH June 3 1875

9. AGE (In years on last birthday) 82 — 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) Retired Merchant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Dallas Co. Mo.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Thomas D. Harris

13b. MOTHER'S MAIDEN NAME Nancy E. Faikner

14. NAME OF HUSBAND OR WIFE Minnie Ann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Mrs. Kathleen Schmoutey Address Lebanon

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 30 min.
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): acute urinary retention 4301

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 7-10-57, to 7-12-57 and last saw ~~her~~ him alive on 7-12-57
Death occurred at 7 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B B Hurst M.D.

22b. ADDRESS Lebanon, Mo.

22c. DATE SIGNED 7-17-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 7/17/57

23c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery

23d. LOCATION (City, town, or county) (State) Conway Mo.

24. FUNERAL DIRECTOR Holman Lebanon, Mo — ADDRESS

25. DATE RECD. BY LOCAL REG. 7-17-1957

26. REGISTRAR'S SIGNATURE Hella L. Hay

(Licensed Embalmer's Statement on Reverse Side)

Received 7-22-57
Laclede County Health Unit
File No. 115
Date Filed 7-22-57

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 Dorsey M. Howe
Licensed Embalmer No. 4222
P. O. Address Lebanon,

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.