

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30725
STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 214

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mexico</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain Hospital</u>		Length of stay in lb <u>7 days</u>	d. STREET ADDRESS <u>R. F. D.</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Pearl</u> Last <u>Harshbarger</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1887</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Bloomington, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Marion Cornelison</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Ragan</u>		14. NAME OF HUSBAND OR WIFE <u>Walter Harshbarger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or years of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>RFD 1</u> <u>Mr. Walter Harshbarger Thompson, 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>myocardial infarction with heart failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u>					
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>4200</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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <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 <u>1947</u> to <u>9-8-57</u> and last saw her alive on <u>Sept 8, 1957</u> Death occurred at <u>5:30 p</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. Hallenbach M.D.</u> (Degree or title)			22b. ADDRESS <u>Mexico, Mo.</u>		22c. DATE SIGNED <u>Sept 9, 1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-10-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Mexico, Missouri</u>
24. FUNERAL DIRECTOR <u>Arnold Funeral Home</u>		ADDRESS <u>Mexico, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept-9-1957</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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: *Riley Taylor*
Licensed Embalmer No. *3237*
P. O. Address *Medford, 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.