Health, & Welfare Public Service

S. 300 1-57

FILED SEP 23 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31551

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 51

1. PLACE OF DEATH
a. COUNTY Harrison
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bethany — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Noll Memorial — Length of stay in 1b 1 wk

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Harrison
c. CITY OR TOWN Blythedale — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) None — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Mattie Middle Ellen Last Harper

4. DATE OF DEATH Month 9 Day 14 Year 57

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 11-20-1890
9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR Months 9 Days 24 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Harrison County Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Samuel P. Jones
13b. MOTHER'S MAIDEN NAME Malinda Carson
14. NAME OF HUSBAND OR WIFE James E Harper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT James E. Harper Address Blythedale Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breast, metastatic — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
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) 170X

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 9/23/55 to 9/14/57 and last saw her alive on 9/14/57
Death occurred at 11:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Merriam Gearhart M.D.
22b. ADDRESS Bethany Mo.
22c. DATE SIGNED 9/17/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 9-17-57
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill
23d. LOCATION (City, town, or county) (State) Blythedale Mo

24. FUNERAL DIRECTOR M B Haas ADDRESS Bethany Mo.
25. DATE RECD. BY LOCAL REG. 9-19-57
26. REGISTRAR'S SIGNATURE Zella Maxey

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed M S Hess
Signature of Student Embalmer

Licensed Embalmer No. 3899
P. O. Address Bethany, 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.