

Health,  
& Welfare  
Public  
Service

FILED DEC 11 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40369  
STATE FILE NUMBER  
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5526

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>3345 TRACY</u>			Length of stay in lb <u>51 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>3345 Tracy</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>W.</u> Last <u>HARMON</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</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>Aug. 13, 1882</u>		9. AGE (In years last birthday) <u>75</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>None</u>		11. BIRTHPLACE (City and state or country) <u>Burlington, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM FROMM</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Charles E. HARMON</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>MR. Charles E. HARMON 3345 TRACY</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of the lungs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Acute Cardiac failure</u> DUE TO (c) <u>Arterio Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>36 Hours</u> <u>48 Hours</u> <u>4500</u>
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.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>Nov 5, 1945</u> to <u>Nov 20<sup>th</sup> 1957</u> and last saw her <u>him</u> alive on <u>Nov 20<sup>th</sup> 1957</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>D. S. Larson, M.D.</u> (Degree or title)				22b. ADDRESS <u>3721 Inwood, K.C. Mo</u>		22c. DATE SIGNED <u>11-22-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 23, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>		
24. FUNERAL DIRECTOR <u>Muehlebach</u>			ADDRESS <u>6800 Troost</u>		25. DATE RECD. BY LOCAL REG. <u>11-22-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

S. S. Tar. son

Dr. Larson  
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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 Richard E. Pichler

Licensed Embalmer No. 4997

P. O. Address 6100 1st St. S.E. Wash. D.C. 20005

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.