

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**58-017501**

STATE FILE NUMBER

310 ~~308~~

**FILED MAY 21 1958**

Registration District No. 53 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Alexander</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Cairo</b> <span style="float:right">8120</span>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>So. East Mo. Hospt. 6 Days</b>		Length of stay in <b>6 Days</b>	d. STREET ADDRESS (If outside, give location) <b>526 - 23rd Street</b>
3. NAME OF DECEASED (Type or print) First <b>Prince</b> Middle <b>Harrison</b> Last _____			4. DATE OF DEATH <b>May 3, 1958</b> Month <b>May</b> Day <b>3</b> Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>3</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1904</b>
9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	11. BIRTHPLACE (City and state or country) <b>Colp, Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Walter Harrison</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	
16. SOCIAL SECURITY NO. <b>322-12-4667</b>		17. INFORMANT <b>526 - 23rd St. Cairo, Ill. Gladys Lee Jones</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>4201</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>Chronic Duodenal Ulcer</b>			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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <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 <b>4-28-58</b> to <b>5-3-58</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>5-3-58</b> Death occurred at <b>150/AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deputy or title) <b>W. Sheehan, M.D.</b>		22b. ADDRESS <b>Cape Girardeau Mo.</b>	22c. DATE SIGNED <b>5-9-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/8/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spencer Heights</b>	23d. LOCATION (City, town, or county) (State) <b>Mounds, Illinois</b>
24. FUNERAL DIRECTOR <b>Edward J. Puffinberger</b>	ADDRESS <b>2501 Poplar St. Cairo, Illinois</b>	25. DATE RECD. BY LOCAL REG. <b>May 15, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Homer C. Cooper</b>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAY 22 1958

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.....  
*Edward A. Ruffin*

Licensed Embalmer No... 502  
2501 Poplar Street  
P. O. Address Cairo, Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.