

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039671

STATE FILE NUMBER

FILED DEC 9 1958

Registration District No. 133 Primary Registration District No.

Registrar's No. 153

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>HARRISON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>HARRISON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Blythedale</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Blythedale</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in lb <u>9 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>None</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Marie</u> Last <u>Harris</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>27</u> Year <u>1958</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>March 16, 1893</u>	9. AGE (In years last birthday) <u>65</u>	FUNDED 1 YEAR Months Days Hours Min.
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>Housekeeping</u>	11. BIRTHPLACE (City and state or country) <u>Ridgeway, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Charles Moore</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Moore</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Harris</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>No</u>	17. INFORMANT Address <u>Charles Harris, Blythedale 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>Acute Coronary Artery Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 OR 75</u>
Conditions, if any, which gave rise to, above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Arteriosclerosis</u>					<u>10 yrs</u>
DUE TO (c) <u>Hypertension</u>					<u>4201</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus; Paralysis of Larynx and Pharynx</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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>Jan 29, 1954</u> to <u>NOV 27, 1958</u> and last saw her/him alive on <u>NOV 27, 1958</u> Death occurred at <u>9:00</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr Francis S. Kou</u>			22b. ADDRESS <u>D.O. Eagleville, Mo</u>		22c. DATE SIGNED <u>NOV. 29, 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 30, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Blythedale Mo</u>	
24. FUNERAL DIRECTOR <u>Ronald W. Boggess, Eagleville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 30-1958</u>		26. REGISTRAR'S SIGNATURE <u>Gella Mayley</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. No symptoms will be listed.

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 *Herald W. Bogges*

Licensed Embalmer No. *4762*

P. O. Address *Englewood, M*

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.