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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-043020
STATE FILE NUMBER

FILED NOV 17 1958 Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 114

1. PLACE OF DEATH
a. COUNTY Sullivan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Milan — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Sullivan
c. CITY OR TOWN Milan — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS 105 (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Rebecca Middle: Last: Harrelson
4. DATE OF DEATH Month 11 Day 4 Year 1958
5. SEX Fem
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 3-22-1864
9. AGE (In years last birthday) 94 — IF UNDER 1 YEAR Months 7 Days 12 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (City and state or country) Putman Co. Mo
12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME Samuel Harrington
13b. MOTHER'S MAIDEN NAME Mary Lee Harrington
14. NAME OF HUSBAND OR WIFE Lee Harrelson - (dead)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mollie Leach Address Milan Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 2 years
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) 4222
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 1-1-57 to 11-4-58 and last saw her/him alive on 11-4-58
Death occurred at 5:45 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE V Robinson (Degree or title) MD
22b. ADDRESS Milan Mo
22c. DATE SIGNED 11-5-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11-6-58
23c. NAME OF CEMETERY OR CREMATORY Campbell Cem
23d. LOCATION (City, town, or county) Pollock (State) Mo

24. FUNERAL DIRECTOR Schreyer & Dwight Schreyer ADDRESS Milan Mo
25. DATE RECD. BY LOCAL REG. 11-10-58
26. REGISTRAR'S SIGNATURE Mrs. M.W. Beckett

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan, 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.