. Health,
& Welfare
Public
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S. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005595
STATE FILE NUMBER

FILED FEB 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 679

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Missouri — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran — Length of stay in 1b 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Anderson.
c. CITY OR TOWN Garnett 8150 8 — Inside Limits Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location) 405 W. 4th. — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First Dr. Claib Middle B. Last Harris, Sr.
4. DATE OF DEATH Month Feb. Day 4 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH Aug. 31, 1876
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor
10b. KIND OF BUSINESS OR INDUSTRY Medicine
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Claib B. Harris
13b. MOTHER'S MAIDEN NAME Hannah Bosworth
14. NAME OF HUSBAND OR WIFE Sue Harris
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. none
17. INFORMANT Dr. C. B. Harris, Jr. Address Garnett, Ks.

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) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 30 mi
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis — 5 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) no 4201
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 2/3/59, to 2/4/59 and last saw him alive on 2/4/59
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. A. Tesson (Degree or title) M.D.
22b. ADDRESS 907 Rialto Bldg
22c. DATE SIGNED 2/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Feb. 5, 1959
23c. NAME OF CEMETERY OR CREMATORY Garnett - Cem.
23d. LOCATION (City, town, or county) (State) Garnett, Kansas

24. FUNERAL DIRECTOR ADDRESS Stine & McClure Und. Co., K.C., Mo.
25. DATE RECD. BY LOCAL REG. 2-5-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

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.

J. A. Tesson

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.