

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5953 59-014412

STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. 278 Primary Registration District No. 5953 Registrar's No. 61

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All diseases in Part I must be causally related.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BUFFALO</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Wauzalia</u> 0041 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>Highway 54</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ALBRO JERT HARRIS</u>			4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</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>May 2, 1910</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Crain Fuel Gas</u>	9. AGE (In years last birthday) <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MO</u>
10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10d. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13a. FATHER'S NAME <u>Homer Harris</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Della Harris</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give no. & dates of service.) <u>World War 2</u>		16. SOCIAL SECURITY NO. <u>498-40-1240</u>	17. INFORMANT <u>Wife</u> Address <u>Louisiana MO</u>
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Fracture</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
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)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input checked="" 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.) <u>automobile accident - two car head-on</u>	
20c. TIME OF INJURY Hour <u>6:10</u> Month <u>4</u> Day <u>20</u> Year <u>59</u> p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Callisville - Highway 54</u>	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Bowling Green Pike</u> COUNTY <u>MO</u> STATE <u>MO</u>	
21. I attended the deceased from _____ to _____ and last saw him/her on <u>April 20-59</u> Death occurred at <u>6:10 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. H. Huddleston</u> (Degree or title) <u>Coroner</u>		22b. ADDRESS <u>Bowling Green, Mo.</u>	22c. DATE SIGNED <u>ap 22 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4/25/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion</u>	23d. LOCATION (City, town, or county) (State) <u>Pike County MO</u>
24. FUNERAL DIRECTOR <u>Sterne Funeral Home</u> ADDRESS <u>Louisiana MO</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 1 1959</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>

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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 .....

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.