

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022500

STATE FILE NUMBER

FILED JUN 22 1959

Registration District No. 390

Primary Registration District No. 4442

Registrar's No.

1. PLACE OF DEATH a. COUNTY Randolph			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Rand.		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Higbee		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Higbee		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb years	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Sam Harold Harlan			4. DATE OF DEATH Month Day Year 6/12/59		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/1880	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Chariton Co., Mo.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Harlan			14. MOTHER'S MAIDEN NAME Eliza Fox		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs. S.H. Harlan Higbee Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Thrombotic Encephalomalacia</i> DUE TO (c) <i>Arteriosclerosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>6 days</i> <i>unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>332X</i>					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 a.m. p.m. Month, Day, Year					
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 <i>6-9-59</i> to <i>6-12-59</i> and last saw him alive on <i>6-12-59</i> Death occurred at <i>5:01</i> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Per Y. Brohmson, D.O.</i>			22b. ADDRESS <i>Higbee</i>		22c. DATE SIGNED <i>6-13-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6/14/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Prairie Hill</i>	23d. LOCATION (City, town, or county) (State) <i>Prairie Hill Missouri</i>		
24. FUNERAL DIRECTOR <i>Marion E. Million</i>		ADDRESS <i>Moberly, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>June 13-59</i>	26. REGISTRAR'S SIGNATURE <i>Joe W. Burton</i>	

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare Public Health Service
S. 300 v. 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.
securing the medical certification in the specific manner required by 193.140 MOKS 1949.

JUN 3 1959

JUN 9 1959

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 *Marion E. [Signature]*

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.