

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028638

FILED VS SEP 14 1959

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 197

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>WASHINGTON</u>		Length of stay in 1b <u>1 WEEK</u>		c. CITY OR TOWN <u>SULLIVAN</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>ELMONT ROAD R.R. I</u>		
3. NAME OF DECEASED (Type or print) First <u>BETH</u> Middle <u>ANN</u> Last <u>HARMICK</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 4, 1959</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		9. AGE (last birthday) <u>6 DAYS</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u>	
11. BIRTHPLACE (City and state or country) <u>WASHINGTON, MO.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>RAY E. HARMICK</u>			13b. MOTHER'S MAIDEN NAME <u>ELSIE M. TEETER</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</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>NONE</u>		17. INFORMANT <u>RAY HARMICK, SULLIVAN, 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>PREMATURITY (27 WEEKS)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>SEPT 4-59</u> to <u>SEPT 10-59</u> and last saw her <u>alive</u> on <u>SEPT 10 1959</u> Death occurred at <u>10:15P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert J. [Signature]</u> (Degree or title)				22b. ADDRESS <u>Sullivan Mo.</u>		22c. DATE SIGNED <u>Sept 11-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>SEPT. 11, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CROW CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SULLIVAN MO</u>	
24. FUNERAL DIRECTOR <u>H.M.EATON</u> ADDRESS <u>SULLIVAN, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>9/12/59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harrison M. Eator

Licensed Embalmer No. 4192

P. O. Address Sullivan

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.