

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028739

FILED VS SEP 14 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 944

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>12 yrs.</u>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1507 N. Farmer</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mila</u> Middle <u>Maie</u> Last <u>Harris</u>			4. DATE OF DEATH Month <u>September</u> Day <u>5</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1883</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Greene County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Lafayette Harris</u>		13b. MOTHER'S MAIDEN NAME <u>Delilah Lemmons</u>		14. NAME OF HUSBAND OR WIFE <u>John Elijah Harris</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>UNKNOWN</u>		17. INFORMANT <u>Mrs. F. P. McCullah-Springfield,</u> Address <u>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>Generalized arteriosclerosis, severe:</u> <u>1. Cerebral thrombi. 2. Nephrosclerosis with renal insufficiency</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>		
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 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 <u>7:00</u> a.m. p.m. Month, Day, Year <u>8-5-47</u>	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 8-5-47 to 9-5-59 and last saw her alive on 9-5-59
Death occurred at 7:00 hr m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. M. King M.D.</u>		22b. ADDRESS <u>1630 N. Jefferson, Springfield, MO</u>		22c. DATE SIGNED <u>9-7-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Greene County Missouri</u>	
24. FUNERAL DIRECTOR <u>Rex Rainey-Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-8-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>	

DOCUMENT

MEDICAL CERTIFICATION

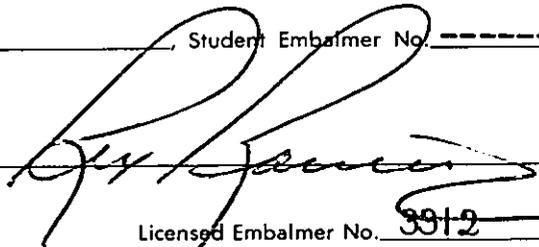
BY AFFIDAVIT OF

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 
Licensed Embalmer No. 3912

P. O. Address Springfield,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.