RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1959

59–030044
STATE FILE NUMBER

Registration District No. 280 Primary Registration District No. _____ Registrar's No. 47

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: PLATTE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: PARKVILLE — Length of stay in 1b: 14 YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. FRANCIS ST. RT. # 5 — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: PLATTE
c. CITY OR TOWN: PARKVILLE — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): ST. FRANCIS Street — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: DILLAN Middle: H. Last: HARRIS
4. DATE OF DEATH: Month AUG Day 6 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6 3 1906
9. AGE (last birthday): 53yrs. — IF UNDER 1 YEAR: Months ____ Days ____ — IF UNDER 24 HR: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FIREMAN AND ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (City and state or country): CHATTENOGA, TENN
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: WILLIAM F. HARRIS
13b. MOTHER'S MAIDEN NAME: LULA LOOPER
14. NAME OF HUSBAND OR WIFE: ADELINE HARRIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 413 10 8276
17. INFORMANT: ADELINE HARRIS Address: PARKVILLE, 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): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
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 1956, to 1959 and last saw him alive on 1 Aug 59.
Death occurred at 4 A. M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title): M.D.
22b. ADDRESS: 1806 Swift Ave. N.K.C. Mo.
22c. DATE SIGNED: 7 Aug 59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: AUGUST 8, 1959
23c. NAME OF CEMETERY OR CREMATORY: CHILHOWEE, CEM
23d. LOCATION (City, town, or county) (State): CHILHOWEE, MO.

24. FUNERAL DIRECTOR: D. W. NEWCOMER'S SONS K. C. MO. ADDRESS
25. DATE RECD. BY LOCAL REG.: Aug 8-1959
26. REGISTRAR'S SIGNATURE: Ophia Rollins.

(Licensed Embalmer's Statement on Reverse Side)

AUG 24 1969

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_____ Signed Chester K Brown

Signature of Student Embalmer

Licensed Embalmer No. K9 3

P. O. Address K2 M

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