

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 1 1959

149 59-031736

Registration District No. 59 Primary Registration District No. Registrar's No. 149

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>CASS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>CASS</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HARRISONVILLE</b>		Length of stay in 1b <b>78yrs</b>		c. CITY OR TOWN <b>HARRISONVILLE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>303 BRADLEY</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>303 BRADLEY</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATIE TILLIE VERNON</b>				4. DATE OF DEATH Month Day Year <b>Sept 22 1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-23-1880</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>HARRISONVILLE, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>SAMUEL HICKS</b>			13b. MOTHER'S MAIDEN NAME <b>FANNIE DAVIS</b>			14. NAME OF HUSBAND OR WIFE <b>SILAS VERNON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mrs GOLDY GOINS HARRISONVILLE, MO.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis, hypertension</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>		
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 checked="" 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 <b>Oct 1950</b> to <b>9-22-59</b> and last saw her/him alive on <b>9-21-59</b> Death occurred at <b>one</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATOR (Degree or title) <b>Edward S. Jones MD</b>				22b. ADDRESS <b>Harrisonville MO</b>			22c. DATE SIGNED <b>9-23-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9-24-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ORIENT CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>HARRISONVILLE, MISSOURI</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Atkinson-Dickey HARRISONVILLE, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>9-23-59</b>		26. REGISTRAR'S SIGNATURE <b>McRay Sebrer</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6561 & NON SA  
NOV 3 1956

**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 Robert Atkinson

Licensed Embalmer No. 4902

P. O. Address Nauvoo

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.