URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 16 1959

59-036890

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 314

ENDED

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Hannibal — Length of stay in 1b: 5 months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Levering Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Marion
c. CITY OR TOWN: Hannibal — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1713 Grace St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Wesley Last: Harrison

4. DATE OF DEATH: Month 10 Day 5 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5-19-89
9. AGE (last birthday): 70
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): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Bethel, Mo.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Wm. H. Harrison
13b. MOTHER'S MAIDEN NAME: Mary F. Jones
14. NAME OF HUSBAND OR WIFE: Florence Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 486-34-9591A
17. INFORMANT: Florence Harrison Address: Hannibal, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Terminal bronchial pneumonia	4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	6-21-58
DUE TO (c)	Arthritis, both knees - chronic cystitis	6-21-58

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 June 21, 1958, to Oct. 5, 1959 and last saw her/him alive on Oct. 5, 1959
Death occurred at 5:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title) MD
22b. ADDRESS: 100 N. 6th, Hannibal, Mo.
22c. DATE SIGNED: 10-7-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10-7-1959
23c. NAME OF CEMETERY OR CREMATORY: Grand View Cemetery
23d. LOCATION (City, town, or county) (State): Hannibal, Mo.

24. FUNERAL DIRECTOR ADDRESS: Clark Funeral Home-Hannibal, Mo.
25. DATE RECD. BY LOCAL REG.: Oct 13-59
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Ralph O. Clark

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo.

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