

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1959

59-041085

STATE FILE NUMBER

Registration District No. 245 Primary Registration District No. 3047 Registrar's No. 114

ENDED

1. PLACE OF DEATH a. COUNTY <u>Newton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Neosho</u>		Length of stay in 1b <u>Minutes</u>		c. CITY OR TOWN <u>Anderson</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. Sales Memorial</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>None</u>			Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVERETT</u> Middle <u>LUTHER</u> Last <u>HARRELL</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-1897</u>	9. AGE (last birthday) <u>62</u>	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) <u>Owner of Furniture Store</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (City and state or country) <u>Centerton, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Albert Harrell</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine Seely</u>			14. NAME OF HUSBAND OR WIFE <u>Lula Harrell</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>491-01-6000</u>		17. INFORMANT <u>Mrs. Lula Harrell Anderson, Mo.</u> Address _____				
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>Coronary occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH _____		
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 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 _____ 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>1950</u> to <u>11-6-59</u> and last saw <u>him</u> alive on <u>11-1-59</u> Death occurred at <u>10:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>H. Blankensh, M.D.</u> (Degree or title)				22b. ADDRESS <u>Neosho Mo.</u>			22c. DATE SIGNED <u>11-9-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov. 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Garden</u>		23d. LOCATION (City, town, or county) <u>Neosho, Arkansas</u>		(State) _____		
24. FUNERAL DIRECTOR <u>Roller Funeral Home Anderson, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>Nov. 7, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Merlin C. Bowman M.D.</u> <u>Per R.H.</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 17 1959

JAN 4 1960

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 Robert C. Roller

Licensed Embalmer No. 5062

P. O. Address Anderson, Mo.

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.