

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-019947

FILED VS JUN 13 1960 / 74

Primary Registration District No. 3035 Registrar's No.

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lexington</b>		Length of stay in lb <b>50</b> Years		c. CITY OR TOWN <b>Lexington</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>(home) 12th. &amp; South St.</b>				d. STREET ADDRESS (If outside, give location) <b>12th. &amp; South St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>LILLIAN M. HARRISON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1960</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. BIRTHDAY <b>January 9, 1905</b>		
9. AGE (last birthday) <b>55</b>		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) <b>Housewife &amp;</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (City and state or country) <b>Wagner, Okla.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>M.J. Harrison</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>497-14-0461</b>		17. INFORMANT <b>M.J. Harrison, Lexington, 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>Acute Coronary Thrombosis.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediately.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic myocardial degeneration</b>						<b>6 months</b>		
DUE TO (c) <b>Chronic Arteriosclerosis</b>						<b>5 yrl.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Cardiac Asthma.</b>						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 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 Month, Day, Year a.m. p.m.								
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>January-1943</b> to <b>5/18/60</b> and last saw her alive on <b>5/18/60</b> Death occurred at <b>5:45</b> P. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>John C. Beltram D.O.</b>				22b. ADDRESS <b>Lexington, Mo.</b>		22c. DATE SIGNED <b>5/20/60</b>		
23a. BURIAL, CREMATION, or other FINAL DISPOSITION (Specify) <b>Burial</b>		23b. DATE <b>5/21/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Machpelah Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lexington, Mo.</b>		
24. FUNERAL DIRECTOR <b>Crunk-Walker Lexington, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>5-24-60</b>		26. REGISTRAR'S SIGNATURE <i>Wm E. ...</i>		

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 me

or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Harold P. Walker

Licensed Embalmer No. 4588

P. O. Address Levington

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.