

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-60-024099

STATE FILE NUMBER

FILED VS JUL 7 1960

Registration District No. 282 Primary Registration District No. _____ Registrar's No. 72

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Polk</u>			2. USUAL RESIDENCE (Where deceased lived. If in institution; Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Polk</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rural-</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Bolivar 25492</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>Quirin Car 91</u>		Length of stay in 1b <u>1 hr.</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle _____ Last <u>Harvel</u>			4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1960</u>		
5. SEX <u>Female</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>Jan. 20-1892-68</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>	11. BIRTHPLACE (City and state or country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>William W. Whitehead</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Borer</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>Mo</u>	17. INFORMANT Address <u>Mrs. Evelyn Hestair - Pol. Mo.</u>		
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>Carbon Monoxide Poisoning</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>973.1</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>a Double Suicide by man & wife, near water hose</u>			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		<u>from Exhaust of Car in back window of car.</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Polk</u>		COUNTY <u>CO</u> STATE <u>Mo</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>6:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Clidney F. Pitts - Corona - Co.</u>			22b. ADDRESS <u>Bolivar Mo.</u>		22c. DATE SIGNED <u>June 27-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Banner Creek</u>		23d. LOCATION (City, town, or county) (State) <u>Polk Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Pitts Funeral Home - Bol. Mo.</u>		ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>June 28, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Ralph Hordenpenquell</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Horden

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 *Adney J. Fitts*

Licensed Embalmer No. *4939*

P. O. Address *Bel Air*

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.