

FILED VS AUG 15 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=60-026890
STATE FILE NUMBER
3968

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3968

S. 300
ev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
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.

M. Donald McFarland ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY Lafayette | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Odessa |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke Hospt. | | Length of stay in 1b 66 1 Day. | d. STREET ADDRESS 0540- (If outside, give location) |
| 3. NAME OF DECEASED (Type or print) First Middle Last James Hite Harris | | | 4. DATE OF DEATH Aug. 2, 1960 Month Day Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 8, 1854 |
| 9. AGE (In years birthday) 105 | | FUNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Booneville, Mo. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. | | 13a. FATHER'S NAME James Y. Ewing Harris | |
| 13b. MOTHER'S MAIDEN NAME Margaret Conklin | | 14. NAME OF HUSBAND OR WIFE None | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Address Mrs. Margaret Proctor, Odessa, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour |
| Conditions, if any, which gave rise to above cause (a), stating the under- lying 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) g | | | 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 <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 8/1/60 , to 8/2-60 and last saw ^{her} _{him} alive on 8/1-60 Death occurred at 9:25 a m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Donald M. Farland M.D. C | | 22b. ADDRESS 315 Nichols Road. K.C. Mo | 22c. DATE SIGNED 8-2-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Aug. 2, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery | 23d. LOCATION (City, town, or county) Odessa, Mo. (State) |
| 24. FUNERAL DIRECTOR Husman-Sparks, ADDRESS Odessa, Mo. | | 25. DATE RECD. BY LOCAL REG. 8-2-60 | 26. REGISTRAR'S SIGNATURE H-L. Dwyer, M.D. |

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 *William G. Sparks*

Licensed Embalmer No. *4431*

P. O. Address... *Odessa, N.*

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.