

FEDERAL BUREAU OF INVESTIGATION  
**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-026893**

LED VS JUL 26 1960  
 Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 3592

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>60 Yrs</b>	c. CITY OR TOWN <b>Kansas City</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>Research Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1410 West 41st St.,</b>		
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>L.</b> Last <b>Harrison</b>			4. DATE OF DEATH Month <b>July</b> Day <b>9th</b> Year <b>1960</b>			
5. SEX <b>Male</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. DATE OF BIRTH <b>Sept 12-1887</b>	9. AGE (last birthday) <b>72 Yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Casey Pharmacy</b>	11. BIRTHPLACE (City and state or country) <b>Stilwell, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>John T. Harrison</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Ellen Robbins</b>		14. NAME OF HUSBAND OR WIFE <b>Ada C. 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>486 05 0335</b>	17. INFORMANT <b>Ada C. Harrison</b> Address <b>1410 W. 41st</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>Generalized Peritonitis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last					DUE TO (b) <b>Perforating duodenal ulcer with severe hemorrhage</b>	
					DUE TO (c) <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal illness. If deceased was female was there a pregnancy in last 90 days. <b>Early anterior myocardial infarction</b>						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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						
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>July 7, 1960</b> and last saw <sup>her</sup> him alive on <b>July 9, 1960</b> Death occurred at <b>10:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Carl R. Ferris</b> (Degree or title)		22b. ADDRESS <b>535 1/2 Doyle St., Kansas City 6 Missouri</b>		22c. DATE SIGNED <b>7-11-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 12, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>		
24. FUNERAL DIRECTOR <b>Gates, 1901 Olathe Blvd., K C 3, Ks</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>7-11-60</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>			

DOCUMENT

BY AFFIDAVIT OF  
 Carl R. Ferris  
 MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Murray Wilson

Licensed Embalmer No. 498

P. O. Address Carroll

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