

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028014

FILED VS JUL 27 1960

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 295

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>St Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		Length of stay in lb <b>Lifetime</b>	c. CITY OR TOWN <b>Bonne Terre</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>19 Johnson St</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>19 Johnson St</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Grey</b> Last <b>Harris</b>			4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1960</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-22-1888</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Shirt Factory</b>	11. BIRTHPLACE (City and state or country) <b>East Bonne Terre, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>US</b>
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13a. FATHER'S NAME <b>Newton Harris</b>	13b. MOTHER'S MAIDEN NAME <b>Mae Byington</b>	14. NAME OF HUSBAND OR WIFE <b>Bertha M Foster</b>
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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>490-03-9333</b>	17. INFORMANT <b>Fred Harris</b> Address <b>Bonne Terre, Mo.</b>
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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>Coronary Occlusion</b> DUE TO (b) <b>Hypertension of former attacks &amp;</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH
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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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 <b>Bonne Terre</b>	COUNTY <b>Mo</b>	STATE
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21. I attended the deceased from **July 20 - 1960** to **July 20 - 1960** and saw her/him alive on **July 20 - 1960**  
Death occurred at **Bedroom floor** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>B. Alaric</b> (Degree or title)	22b. ADDRESS <b>Bonne Terre Mo</b>	22c. DATE SIGNED <b>7-22-60</b> (State)
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23a. BURIAL CREATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jul 23, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bonne Terre</b>	23d. LOCATION (City, town, or county) <b>Bonne Terre, Mo</b>
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24. FUNERAL DIRECTOR <b>E. Z. Boyer &amp; Son, Inc.</b> ADDRESS <b>Bonne Terre, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>July 22, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>
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(Licensed Embalmer's Statement on Reverse Side)

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  
or by Burlin T Boyer, Jr, Student Embalmer No. 599  
working under my personal supervision.

Student Burlin T. Boyer, Jr.  
Signature of Student Embalmer

Signed

B. T. Boyer  
Licensed Embalmer No. 36

P. O. Address Desloge, 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.