

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

=60-029948

STATE FILE NUMBER

FILED VS SEP 15 1960

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 84

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Oklahoma</u> b. COUNTY <u>Blaine</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Longdale</u> <u>8350</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Veterans Administration INSTITUTION <u>tion Hospital</u>			Length of stay in lb <u>76 days</u>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIAS VANCE HARMAN</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 24, 1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-1887</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months Days <u>72</u>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Charleston, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Adam Harman</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Bandy</u>			14. NAME OF HUSBAND OR WIFE <u>---</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>			16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT Address <u>James Harman, brother, Longdale, Oklahoma</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>Volvulus of small intestine</u>							INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>5703B</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a). <u>Aneurysm of aorta due to syphilis and tuberculosis, pulmonary, moderately advanced, inactive.</u>							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.) <u>---</u>					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>---</u>			20d. INJURY OCCURRED WHILE AT <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.) <u>---</u>		20f. CITY, TOWN, OR LOCATION <u>---</u>			COUNTY <u>---</u>		STATE <u>---</u>	
21. Attended the deceased from <u>June 9, 1960</u> to <u>Aug. 24, 1960</u> and <u>performed autopsy</u> Death occurred at <u>12:50</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>S. C. STROFF, M.D., Acting Pathologist</u>				22b. ADDRESS <u>VACC, Excelsior Springs Div., Wadsworth, Kansas</u>			22c. DATE SIGNED <u>8-25-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8/25/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNKNOWN</u>			23d. LOCATION (City, town, or county) (State) <u>Fairview, Oklahoma</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Excelsior Spgs, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>8.27-60</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</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

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 *Ralph Van Landingham*

Licensed Embalmer No. *4009*  
P. O. Address *Excelsior Springs, 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.