RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 7 1960

60-038029
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1097

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield
Length of stay in 1b: 35 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL ~~OR INSTITUTION~~ St Johns Hosp
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Douglas
c. CITY OR TOWN Mansfield
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Rt 2
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Neoska Middle May Last Harvey
4. DATE OF DEATH: Month Oct. Day 31 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Dec. 5 1885
9. AGE (last birthday): 74
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Sarcoxie Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Charles Harris
13b. MOTHER'S MAIDEN NAME: Marietta Clouser
14. NAME OF HUSBAND OR WIFE: George
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 553-30-3824
17. INFORMANT: Mrs. J.H. McVay Address: Ava Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cord compression at T-5 — INTERVAL BETWEEN ONSET AND DEATH: 1 month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Tuberculous spondylitis — 8 months
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Rheumatic Heart Disease with Mitral Stenosis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE 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 9-26, to 10-31 and last saw (her) (him) alive on 10-31-60
Death occurred at 10 30 pm on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Neil R Auner (Degree or title) MD
22b. ADDRESS 600 S Glenstone Springfield Mo
22c. DATE SIGNED 11-2-60
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Nov. 1, 1960
23c. NAME OF CEMETERY OR CREMATORY: Mansfield
23d. LOCATION (City, town, or county) (State): Mansfield Mo.
24. FUNERAL DIRECTOR: Max L Miller ADDRESS: Mansfield Mo
25. DATE RECD. BY LOCAL REG.: 11-4-60
26. REGISTRAR'S SIGNATURE: Effie G. Meeter

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Max L Miller

Signature of Student Embalmer

Licensed Embalmer No. 4720

P. O. Address Mansfield

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