

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 21 1960

-60-041446

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 165 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>COOPER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>MORGAN</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOONVILLE</u>		Length of stay in 1b <u>12 DAYS</u>		c. CITY OR TOWN <u>VERSAILLES</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST-JOSEPH HOSPITAL</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>MORGAN TOWNSHIP</u>			
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>B.</u> Last <u>HARRIS</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>16</u> Year <u>1960</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAU.</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/11/89</u>			
9. AGE (last birthday) <u>70</u>		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) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>PLATTE County, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>ALBERT WALLACE</u>			13b. MOTHER'S MAIDEN NAME <u>HULDA CANNON</u>			14. NAME OF HUSBAND OR WIFE <u>JOHN F. HARRIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN F. HARRIS</u> Address <u>VERSAILLES, MO.</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>Medicine Cerebrovascular accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension - arterial ^{cardiovascular} heart disease</u>							Unknown		
DUE TO (c)									
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 checked="" 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.)					
20c. TIME OF INJURY Hour a.m. p.m.		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 <u>10-3-60</u> to <u>10-16-60</u> and last saw her ^{him} alive on <u>11-15-60</u> Death occurred at <u>2:45 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>B. M. Stuart, M.D.</u>				22b. ADDRESS <u>329 Main; Boonville, MO</u>				22c. DATE SIGNED <u>11-16-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>16 Nov. 60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>VERSAILLES CEMETERY</u>		23d. LOCATION (City, town, or county) <u>VERSAILLES, MO.</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>KIDWELL FUNERAL HOME VERSAILLES, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>11/16/60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 9 1961

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 _____
Signature of Student Embalmer

Signed

Raymond C. Foster

Licensed Embalmer No. 4626

P. O. Address Versailles, 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.