

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-045268**

FILED VS DEC 19 1960

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 650

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>DENT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>65 DAYS</b>	c. CITY OR TOWN <b>SALEM</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE FIVE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM HENRY HARRINGTON</b>	4. DATE OF DEATH Month Day Year <b>NOVEMBER 30, 1960</b>
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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>9-25-94</b>	9. AGE (last birthday) <b>66</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>RETIRED PRISON GUARD</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>GUARD STATE PRISON</b>	11. BIRTHPLACE (City and state or country) <b>BLOOMINGTON, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>CHARLES MORRIS HARRINGTON</b>	13b. MOTHER'S MAIDEN NAME <b>AMELIA YOUNG</b>	14. NAME OF HUSBAND OR WIFE <b>THELMA HARRINGTON</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>YES WWI</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>THELMA HARRINGTON, WIFE, SAME AS 2c&amp;d</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>BRONCHOGENIC CARCINOMA, LEFT LOWER LOBE OF LONG WITH SUBCUTANEOUS METASTASES.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS.</b>
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CHRONIC PULMONARY EMPHYSEMA.</b>		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
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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 Month, Day, Year Hour s.m. p.m.	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
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21. attended the deceased from <b>SEPTEMBER 26, 1960</b> to <b>NOV. 30, 1960</b> Death occurred at <b>10:45AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Robert S. Cohen, M.D., Chief, Medical Svc. VA Hospital, Poplar Bluff, Mo.</b>	22b. ADDRESS	22c. DATE SIGNED <b>12/2/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Dec 3, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Granville Illinois</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Max L. Wray, Salem, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12/9/60</b>	26. REGISTRAR'S SIGNATURE <b>R. Muntree</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 21 1960

VS - DEC 20 1960

**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 Philip J. Cassidy

Licensed Embalmer No. 4618

P.O. Address Poplar City

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.