

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009391

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 77

**FILED MAR 29 1961**

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u>		c. CITY OR TOWN <u>Carterville</u>	
Length of stay in 1b <u>5 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McCune-Brooks hospital</u>		d. STREET ADDRESS (If outside, give location) <u>502 E. Main St</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>HARRISON</u> Last <u>HARRISON</u>			4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1961</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</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>8-15-84</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min. <u>    </u>

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>at home</u>		11. BIRTHPLACE (City and state or country) <u>Clarence, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Wm H. H. Dreese</u>			13b. MOTHER'S MAIDEN NAME <u>India Bradley</u>			14. NAME OF HUSBAND OR WIFE <u>Merle Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Merle Harrison, 502 E. Main, Mo.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Acute myocardial failure due to</u>			<u>6 days</u>		
DUE TO (b) <u>Arteriosclerotic heart disease</u>			<u>2 years</u>		
DUE TO (c) _____					

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus (20 years)</u>			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.)			
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 <u>Carthage, Mo</u>	COUNTY _____	STATE _____
21. I attended the deceased from <u>4/11/47</u> to <u>3-18-61</u> and last saw her/him alive on <u>3-18-61</u> Death occurred at <u>9:25</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Charles H. Sowell</u> MD		22b. ADDRESS <u>1515 Hazel, Carthage, Mo</u>		22c. DATE SIGNED <u>3-18-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>3-21-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>Carthage, Mo</u>	
24. FUNERAL DIRECTOR <u>Knell Mortuary, Carthage, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Ell Clutter</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

MAY 3 1962

**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 Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage, 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.