

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012879

STATE FILE NUMBER

AMENDED

Registration District No. 389 Primary Registration District No. 5173 Registrar's No. 9

FILED MAY 5 1961

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holtsummit</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>Holtsummit</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>Summit Drive</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Summit Drive</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Hubert</u> Last <u>Harlan</u>	4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1961</u>
--	---

5. SEX <u>Male</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>Aug 3 1977</u>	9. AGE (last birthday) <u>83</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>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Bedford Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>Nathan Hunt Harlan</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Stokes</u>	14. NAME OF HUSBAND OR WIFE <u>MARY JANE Harlan</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>	17. INFORMANT <u>HOMER W. Harlan Newberg 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>Carcinoma lung metastatic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)	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 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>Jan 5 59</u> to <u>April 23 61</u> last saw him alive on <u>4-23-61</u> Death occurred at <u>10:20 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Green A. Dwyer M.D.</u>	22b. ADDRESS <u>Jefferson City Mo</u>	22c. DATE SIGNED <u>4/24/61</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/26/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Holtsummit Mo</u>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Claypool Service New Bloomfield</u>	ADDRESS <u>4/24/61</u>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>LeRoy Claypool</u>
--	---------------------------	------------------------------	--

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed LeRoy Claypool
Licensed Embalmer No. 4412

P. O. Address New Bloomfield Pa

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.