

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016347  
STATE FILE NUMBER

AMENDED

Registration District No. 4 Primary Registration District No. \_\_\_\_\_ Registrar's No. 55

FILED MAY 23 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clay Twsp.</u>		Length of stay in 1b		c. CITY OR TOWN <u>Rock Port.</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>none</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>none</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Harris</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>5</u> Day <u>17</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>2-14-1894</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	IF UNDER 24 HR Hours <u>3</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (City and state or county) <u>Parthenon, Ark</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>		
13a. FATHER'S NAME <u>Ben Harris</u>			13b. MOTHER'S MAIDEN NAME <u>Zillia Cisco</u>			14. NAME OF HUSBAND OR WIFE <u>Ida May 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>					17. INFORMANT <u>Mrs Jack Wilson</u> Address <u>Rock Port.</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>GUNSHOT TO HEAD</u>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>INTRA CRANIAL HEMORRHAGE</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>GUNSHOT</u>							
20c. TIME OF INJURY <u>8:00</u> Hour <u>8:00</u> a.m. <u>8:00</u> p.m.	Month, Day, Year <u>5 17 61</u>								
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.) <u>2 MI WEST ROCK PORT, MO</u>		20f. CITY, TOWN, OR LOCATION _____		COUNTY _____		STATE _____	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>D. Gallup</u> (Degree or title) <u>Coroner</u>				22b. ADDRESS <u>Rock Port, Mo</u>			22c. DATE SIGNED <u>5-17-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-19-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>High Creek Cem.</u>		23d. LOCATION (City, town, or county) <u>Watson, Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Bartholomew Mortuary, Rock Port</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>May 20, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Tharvin A. Schaefer</u>			

JAN 8 1963

**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 *Ernst Berthelme*

Licensed Embalmer No. 3173

P. O. Address *Box 101, Md*

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.