

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018547

AMENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 69

STATE FILE NUMBER

FILED MAY 31 1961

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>LOUISIANA</u>		Length of stay in ib <u>6 MO</u>		c. CITY OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) <u>804 JACKSON ST.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>804 JACKSON ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>VIRGIE MAE HARRINGTON</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>1961</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</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>11-16-1890</u>		9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>CLARKSVILLE MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>ELIJAH FURMAN</u>				13b. MOTHER'S MAIDEN NAME <u>MILDRED REYNOLDS</u>				14. NAME OF HUSBAND OR WIFE <u>JAMES HARRINGTON</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. <u>NONE</u>		17. INFORMANT <u>RUDOLPH LEVELS. CLARKSVILLE</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>Increased intracranial pressure (Medullary stroke)</u>										<u>Immediate</u>			
DUE TO (b) <u>Massive Sub arachnoid Hemorrhage</u>										<u>Immediate</u>			
DUE TO (c) <u>Advanced arteriosclerosis</u>										<u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Severe Hypertension</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			
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.)									
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>July 1959</u> to <u>May 22/1961</u> and last saw her/him alive on <u>May 1/61</u> Death occurred at <u>12:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>David L. Bilyea</u> (Degree or title)						22b. ADDRESS <u>218 N 5th St Louisiana</u>			22c. DATE SIGNED <u>May 23/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)						
<u>BURIAL</u>		<u>MAY 24-61</u>		<u>GREEN WOOD CEM.</u>			<u>CLARKSVILLE MO</u>						
24. FUNERAL DIRECTOR <u>GEO. M. COLLIER</u> ADDRESS <u>LOUISIANA</u>				25. DATE RECD. BY LOCAL REG. <u>May 27-61</u>		26. REGISTRAR'S SIGNATURE <u>Bevise Collier</u>							

(Attach Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 Geo. M. Collier

Licensed Embalmer No. 3839

P. O. Address Louisiana

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.