

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020241

STATE FILE NUMBER

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 177

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUL 10 1961

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkville		Length of stay in 1b 9 weeks	c. CITY OR TOWN LaPlata Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR NURSERY Kirkville Osteopathic		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route # 4 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WEBSTER Middle McKINLEY Last HARDEN			4. DATE OF DEATH Month July Day 4 Year 1961
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/18/96
9. AGE (last birthday) 64		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) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Turkey	11. BIRTHPLACE (City and state or country) Sullivan Co. Mo.
12. CITIZEN OF WHAT COUNTRY U S		13a. FATHER'S NAME William Calvin Harden	
13b. MOTHER'S MAIDEN NAME Hester Ann Tipton		14. NAME OF HUSBAND OR WIFE Elsie Opal Long Harden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		17. INFORMANT Address Elsie Harden, Rt. 4, LaPlata, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Failure DUE TO (b) Hemorrhage DUE TO (c) Duodenal ulcer Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cholelithiasis			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 2:25 a.m. p.m.	Month, Day, Year 6-26-61		
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.) Winnigan	20f. CITY, TOWN, OR LOCATION Winnigan, Sullivan, Mo.	COUNTY STATE
21. I attended the deceased from 6-26-61 to 7-4-61 and last saw him alive on 7-4-61 Death occurred at 2:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. Meaney D.O.		22b. ADDRESS Kirkville, Mo.	22c. DATE SIGNED 7-5-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/6/61	23c. NAME OF CEMETERY OR CREMATORY Winnigan	23d. LOCATION (City, town, or county) (State) Winnigan, Sullivan, Mo.
24. FUNERAL DIRECTOR Foster Memorial Home, Kirkville, Mo.		25. DATE RECD. BY LOCAL REG. July 6, 1961	26. REGISTRAR'S SIGNATURE Doro W. Gatliff

JUL 13 1961

W. E. MEANEY, D.O.

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

Nova E. Foster
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, 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.