

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

97 -61-032663  
STATE FILE NUMBER

AMENDED

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 97

**FILED OCT 3 1961**

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette, Missouri</b>		c. CITY OR TOWN <b>Fayette</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lee Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>N. Moniteau Twp.</b>	

3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>MITCHELL</b> Last <b>HARRIS</b>	4. DATE OF DEATH Month <b>Sept.</b> Day <b>30</b> Year <b>1961</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/13/1878</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>5</b>	IF UNDER 24 HR Hours <b>2</b> Min. <b>45</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Howard County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>James Mitchell</b>	13b. MOTHER'S MAIDEN NAME <b>Caroline Meek</b>	14. NAME OF HUSBAND OR WIFE <b>James Buford Harris</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs Alfred Rains, St. Charles Mo.</b>
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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) <b>Uremic Coma</b>		<b>2 1/2 hrs</b>
Conditions, if any, which gave rise to above cause (s), stating the underlying cause last.	DUE TO (b) <b>Chronic Yasthritis</b>	<b>2 yrs</b>
	DUE TO (c) <b>Arteriosclerosis</b>	<b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Psychosis</b>		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 type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <b>9:00</b> a.m. Month, Day, Year <b>9-15-61</b>	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 <b>Fayette</b> COUNTY <b>Mo</b> STATE <b>Mo</b>
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21. I attended the deceased from <b>9-15-61</b> to <b>9-30-61</b> and last saw her alive on <b>9-30-61</b> Death occurred at <b>9:00 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>W. Bloom Jr. D.</b> (Degree or title)	22b. ADDRESS <b>Fayette Mo</b>	22c. DATE SIGNED <b>9-30-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/2/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) <b>Fayette, Missouri</b> (State)
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24. FUNERAL DIRECTOR <b>Ralph A. Carr</b> ADDRESS <b>Fayette, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-30-61</b>	26. REGISTRAR'S SIGNATURE <b>Katherine Welsh</b>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Jayette 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.