

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-033456

AMENDED

Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 31

STATE FILE NUMBER

FILED SEP 20 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Lafayette</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Odessa</u> | | Length of stay in lb <u>6 mos</u> | c. CITY OR TOWN <u>Odessa</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>314 E. Mason</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>314 E. Mason</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>none</u> Last <u>Harris</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1961</u> |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-18-1881</u> |
| 9. AGE (last birthday) <u>79</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>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeping</u> | 11. BIRTHPLACE (City and state or country) <u>Terra Haute, Ind</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>James Hathcock</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Alice Stewart</u> | | 14. NAME OF HUSBAND OR WIFE <u>Alexander 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> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | 17. INFORMANT <u>Mrs. Millie Brooks, Odessa, Mo.</u> Address _____ |
| 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>Cardiac & Respiratory failure</u> DUE TO (b) <u>diabetes</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> |
| 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"/> 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.) | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. | | | |
| 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>9-11-61</u> to <u>9-19-61</u> and last saw her <u>alive</u> on <u>9-18-61</u> Death occurred at <u>9-19-61</u> <u>7:05</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Roy Owen D.D.</u> (Degree or title) | | 22b. ADDRESS <u>Odessa, Mo</u> | 22c. DATE SIGNED <u>9-19-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal-burial</u> | 23b. DATE <u>9-25-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Tahoma Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Yakima, Washington</u> |
| 24. FUNERAL DIRECTOR <u>Ralph O. Jones, Odessa, Missouri</u> ADDRESS _____ | | 25. DATE RECD. BY LOCAL REG. <u>9-19-1961</u> | 26. REGISTRAR'S SIGNATURE <u>Emma Davison</u> |

SEP 26 1961

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 O. Jones

Licensed Embalmer No. 4604

P. O. Address Odessa, 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.