

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036280

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 202

FILED NOV 13 1961

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR North Kansas city		Length of stay in 1b 12 days	c. CITY OR TOWN North Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION N.K.C. Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 830 E.22nd Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle PERSILLA Last HARRIS			4. DATE OF DEATH Month November Day 7 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1876	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Freemont Co. Iowa	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Allen Darnell	13b. MOTHER'S MAIDEN NAME Martha Mick	14. NAME OF HUSBAND OR WIFE Mr. James M. Harris
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. Henry Harris 830 E.22nd Ave. NKC
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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) Bronchopneumonia		2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic Heart Disease	
	DUE TO (c) with decompensation	10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prostate mellitus	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
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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 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
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21. I attended the deceased from 1954 to 11-7-61 and last saw her alive on 11-7-61
Death occurred at 7:10 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert G. Goble, M.D.	22b. ADDRESS 329. Armore north N.C. 16 mo	22c. DATE SIGNED 11-8-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 9-1961	23c. NAME OF CEMETERY OR CREMATORY Antioch Cemetery	23d. LOCATION (City, town, or county) (State) Holt, Missouri
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24. FUNERAL DIRECTOR D.W. Newcomers Sons N.K.C. Mo.	25. DATE RECD. BY LOCAL REG. 11-8-61	26. REGISTRAR'S SIGNATURE Marquitta Rodgers
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Robert Hodde
N.K.C.

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 John M. Hallock
Licensed Embalmer No. 4949
P. O. Address No. Kansas

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.