

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040573

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Primary Registration District No. \_\_\_\_\_ Registrar's No. 52

FILED NOV 22 1961

1. PLACE OF DEATH a. COUNTY <b>DeKalb</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>DeKalb</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maysville</b>		Length of stay in 1b <b>60yrs</b>		c. CITY OR TOWN <b>Maysville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Sunset Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>IDEN</b> Last <b>HARMON</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1961</b>									
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>1-1-1873</b>		9. AGE (last birthday) <b>88</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Green Bay Wisc.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>					
13a. FATHER'S NAME <b>Philip Eyer</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>Ben Harmon</b>					
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.		17. INFORMANT <b>201 East 50th St, A.W.Eyers, Kansas City, Mo</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Endocarditis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>25 yrs</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
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 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 _____ 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 <i>March 1945</i> to <i>Nov 2, 1961</i> and last saw her <i>Nov 1, 1961</i> alive on _____ Death occurred at <i>5:15 A.</i> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Harold Fowler M.D.</i>				22b. ADDRESS <b>Maysville Missouri</b>				22c. DATE SIGNED <i>11/4/61</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 3 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maysville</b>		23d. LOCATION (City, town, or county) <b>Maysville Missouri</b>							
24. FUNERAL DIRECTOR <b>Pfeifer Funeral Home</b>				ADDRESS <b>, Maysville Mo</b>		25. DATE RECD. BY LOCAL REG. <b>11-18-61</b>		26. REGISTRAR'S SIGNATURE <i>Arthur E. Davidson</i>					

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

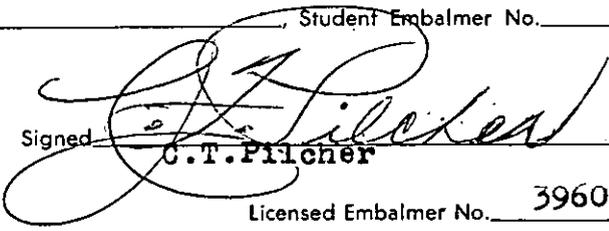
ITEM NO. SHOULD READ

**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   
C.T. Pilcher

Licensed Embalmer No. 3960

P. O. Address Maysville 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.