

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-041890

Registration District No. 264 Primary Registration District No. _____ Registrar's No. 43 STATE FILE NUMBER

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

FILED DEC 4 1961

1. PLACE OF DEATH
a. COUNTY **Ozark**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MO.** b. COUNTY **Ozark**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Barren Fork** Length of stay in 1b **Life** c. CITY OR TOWN **Romance** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Home** Inside Limits Yes No d. STREET ADDRESS (If outside, give location) **Farm** Reside on Farm Yes No

3. NAME OF DECEASED First **James** Middle **Washington** Last **Harley** 4. DATE OF DEATH Month **11** Day **20** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **7-25-77** 9. AGE (last birthday) **84** 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 **Farm** 11. BIRTHPLACE (City and state or country) **Ozark Co., Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **James W. Harley** 13b. MOTHER'S MAIDEN NAME **Eveline Loftis** 14. NAME OF HUSBAND OR WIFE **Ozina Gentry**

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 Address **Eunice Watson, Romance, 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) **Cerebral Thrombosis** INTERVAL BETWEEN ONSET AND DEATH **7 days**
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) **Prostatic Hypertrophy of retention** PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 _____ s.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **October 1959** to **Nov. 20 1961** and last saw her **Nov. 15, 1961** and last saw him **Nov. 15, 1961** Death occurred at **2:30 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **M. J. Haerman MD** 22b. ADDRESS **Gainesville, Mo** 22c. DATE SIGNED **11-21-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **burial** 23b. DATE **11-24-61** 23c. NAME OF CEMETERY OR CREMATORY **Loftis** 23d. LOCATION (City, town, or county) (State) **Ozark County, Missouri**

24. FUNERAL DIRECTOR ADDRESS **Clinkingbeard, Gainesville, Mo.** 25. DATE RECD. BY LOCAL REG. **Nov. 22-61** 26. REGISTRAR'S SIGNATURE **Thane Mahan**

DEC -5 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

John R. Clary

Licensed Embalmer No. 4885

P. O. Address Gainesville, 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.