

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035290

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 171

FILED SEP 17 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
Rev. 4/59		
10531	INSTEAD OF	DOCUMENT
20535		
3	BY AFFIDAVIT OF	MEDICAL CERTIFICATION
4 1		
5 2	SHOULD READ	ITEM NO.
6		
7 0	BY AFFIDAVIT OF	MEDICAL CERTIFICATION
8 2		
9443X	SHOULD READ	ITEM NO.
10		
11	SHOULD READ	ITEM NO.
1290-0		
131-0	SHOULD READ	ITEM NO.

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in lb <u>3 yrs</u>	c. CITY OR TOWN <u>Lebanon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>387 North St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>387 North St.</u>
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>J.</u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</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>12/16/83</u>
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>-</u>	9. AGE (last birthday) <u>78</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Pulaski Co. Mo. U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Franklin B. Harris</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Morrison Ellis Carter</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>none</u>	
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>acute femoral thrombosis, rt. leg.</u>		17. INFORMANT <u>Cecil J. Harris Richland Mo.</u> Address	
DUE TO (b) <u>Hypertensive heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
DUE TO (c)		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral vascular accident 1yr ago</u>		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.)	
20c. TIME OF INJURY Hour <u>12:30</u> a.m. p.m. Month, Day, Year <u>3-23-56</u>	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>3-23-56</u> to <u>9-14-62</u> and last saw her <u>him</u> alive on <u>9-4-62</u> Death occurred at <u>12:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>R B Hurst M.D.</u>	
22b. ADDRESS <u>255 N. ADAMS, LEBANON, MO</u>		22c. DATE SIGNED <u>9-14-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/16/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hazelgreen Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Laclede Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Dorsey M. Howe Lebanon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-14-1962</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. May</u>

**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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.

Permit issued 9-14-1962 M.A.M.