

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042394

STATE FILE NUMBER

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 59

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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2440

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<p>FILED NOV 20 1962</p> <p>1. PLACE OF DEATH a. COUNTY <u>HOLT</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEWIS TWP.</u> Length of stay in lb <u>24 DAYS</u></p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PLEASANT Hill Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u></p> <p>c. CITY OR TOWN <u>MOUND City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>BERT S. HARPER</u></p>		<p>4. DATE OF DEATH Month Day Year <u>NOV. 12 1962</u></p>				
<p>5. SEX <u>MALE</u></p>	<p>6. COLOR OR RACE <u>WHITE</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>9-17-1872</u></p>	<p>9. AGE (last birthday) <u>90</u></p>	<p>IF UNDER 1 YEAR Months Days</p>	<p>IF UNDER 24 HR Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>IOWA</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>JOHN HARPER</u></p>			<p>13b. MOTHER'S MAIDEN NAME <u>ELIZA HUNT</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>			<p>16. SOCIAL SECURITY NO. <u>NONE</u></p>		<p>17. INFORMANT Address <u>PEARSON FUNERAL HOME, ONAWA, I.A.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>arterio-sclerotic</u></p> <p style="text-align: center;">DUE TO (b) <u>Heart Disease</u></p> <p style="text-align: center;">DUE TO (c) _____</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>						
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>				<p>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</p>		
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>				
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>						
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>		
<p>21. I attended the deceased from <u>1-26-61</u> to <u>Nov 12-62</u> and last saw her alive on <u>Nov 11-62</u> Death occurred at <u>6:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>						
<p>22a. SIGNATURE (Degree or title) <u>Dr Perry MD</u></p>			<p>22b. ADDRESS <u>Mound City Mo</u></p>		<p>22c. DATE SIGNED <u>11-13-62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u></p>		<p>23b. DATE <u>11-12-1962</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>SPRING VALLEY</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>MOORHEAD, IOWA</u></p>	
<p>24. FUNERAL DIRECTOR ADDRESS <u>JAMES H. CRAWFORD Mound City, Mo</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>11-12-1962</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u></p>		

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 James H. H. Jones

Licensed Embalmer No. 4796

P. O. Address Trout City, 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.