MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043605
STATE FILE NUMBER

Registration District No. 272 Primary Registration District No. 4403 Registrar's No. 20

FILED NOV 20 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY Bemiscot
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Steele — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 409 Garland — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Bemiscot
c. CITY OR TOWN Steele — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 409 Garland — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Middle Last: Callie Francis Harrison

4. DATE OF DEATH Month Day Year: 11-9-62

5. SEX F
6. COLOR OR RACE White
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 5-22-97
9. AGE (last birthday) 65 — IF UNDER 1 YEAR Months 5 Days 17 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Denton Mo.
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME John Connell
13b. MOTHER'S MAIDEN NAME Rachael Creal
14. NAME OF HUSBAND OR WIFE T.B. Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Tom B Harrison — Address Steele Mo

MEDICAL CERTIFICATION

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 hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis — 4 or 5 years
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. ☐ 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 a.m. p.m. Month, Day, Year
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 1-6-60, to and last saw her alive on 11-9-62
Death occurred at 3:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] MD
22b. ADDRESS Steele Mo
22c. DATE SIGNED 11-10-62

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11-11-62
23c. NAME OF CEMETERY OR CREMATORY Mt Zion
23d. LOCATION (City, town, or county) Steele (State) Mo.

24. FUNERAL DIRECTOR Gannon Funeral Home — ADDRESS Steele Mo
25. DATE RECD. BY LOCAL REG. 11-12-62
26. REGISTRAR'S SIGNATURE Esther Callens

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Jim F. McClure

Signature of Student Embalmer

Licensed Embalmer No. 5104

P. O. Address Steele, Missouri

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.