

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

663-039278
STATE FILE NUMBER

Registration District No. 411 Primary Registration District No. 3012 Registrar's No. 129

FILED NOV 14 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

1 6001
2 1.001
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4 0
5 1
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9 157x
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12 2-0
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in 1b <u>1941</u>	c. CITY OR TOWN <u>Excelsior Springs</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>Excelsior Spgs. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>529 Park St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>Harrison</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Miner</u>	9. AGE (last birthday) <u>69</u>
13a. FATHER'S NAME <u>Glen Harrison</u>		13b. MOTHER'S MAIDEN NAME <u>Mary W. Haskell</u>	11. BIRTHPLACE (City and state or country) <u>Sun Shine, MO.</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>[REDACTED]</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from gastric Varix</u>		14. NAME OF HUSBAND OR WIFE <u>Ellen Harrison</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cirrhosis of liver & ascites</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
DUE TO (c) <u>Ca of pancreas</u>		<u>18 mo.</u>	
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 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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Mar 1962</u> to <u>29 Oct. 63</u> and last saw ^{her} him alive on <u>29 Oct. 1963</u> Death occurred at <u>8:50 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George E. Anderson M.D.</u>		22b. ADDRESS <u>Excelsior Springs, Mo</u>	22c. DATE SIGNED <u>10/30/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 31. 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Excelsior Springs, MO.</u>
24. FUNERAL DIRECTOR <u>Hope Fun'l Home, Ex. Spgs. MO.</u>		25. DATE RECD. BY LOCAL REG. <u>10-30-63</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>

USE BLACK INK OR TYPEWRITER RIBBON

NOV 19 1963

Permit issued 10-29-63

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 Chas. Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs, 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.