

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 316
FEB 11 1965

Primary Registration District No. 3017

Registrar's No. 466

STATE FILE NUMBER

0003076

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY-- <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		c. CITY OR TOWN <u>Bismarck</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Cedar St.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C.</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1965</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>5/4/1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (City and state or country) <u>East Bonne Terre USA</u>	
13a. FATHER'S NAME <u>William D. Harris</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Eaves</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>322x</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>Pneumonia</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		14. NAME OF HUSBAND OR WIFE <u>Julia Harris</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. ☐ 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 <u>Bismarck</u> COUNTY _____ STATE _____		
21. I attended the deceased from <u>Jan 17 65</u> to <u>Jan 31 65</u> and last saw him live on <u>Jan 31-65</u> Death occurred at <u>10:55 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. H. Cozear</u> (Degree or title)		22b. ADDRESS <u>Rivermines 170</u>	
22c. DATE SIGNED <u>2-1-65</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 3/1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hamilton Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bismarck Mo.</u>
24. FUNERAL DIRECTOR <u>C.H. Cozear</u> Farmington, Mo.		25. DATE RECD. BY LOCAL REG. <u>Feb 9 1965</u>	
		26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.