

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23782

BIRTH NO. _____		REG. DIST. NO. 224		PRIMARY REG. DIST. NO. 3046		Registrar's No. 466	
1. PLACE OF DEATH a. COUNTY MONITEAU				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MONITEAU			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CALIFORNIA, MO.		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JAMESTOWN (RURAL) 06871			
d. FULL NAME OF HOSPITAL OR INSTITUTION LATHAM HOSPITAL				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) EDITH EMMALINE HARRIS		a. (First)		b. (Middle)		c. (Last)	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH JAN. 21, 1963	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) MONITEAU COUNTY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JERSEY PENNINGTON		13b. MOTHER'S MAIDEN NAME REBECCA DEARING		14. NAME OF HUSBAND OR WIFE WILLIAM HARRIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS FORREST HARRIS, JAMESTOWN, MO.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 10 days 8 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from June 15, 1957, to July 16, 1957, that I last saw the deceased alive on July 15, 1957, and that death occurred at 4 A.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Newton Latham M.D.		23b. ADDRESS California, Mo.		23c. DATE SIGNED 7-16-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 18, 1957		24c. NAME OF CEMETERY OR CREMATORY Union Cemetery		24d. LOCATION (City, town, or county) (State) Jamestown, Moniteau, Mo	
DATE REC'D BY LOCAL REG. 7-17-57		REGISTRAR'S SIGNATURE N.R. Roberts		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WILLIAMS FUNERAL HOME, California, Mo			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 7-25-51

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed 7-25-51 \_\_\_\_\_

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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2854

P. O. Address California 5th

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 this body is not embalmed, fact should be so stated above.