

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0033926

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 336 Primary Registration District No. 6131 Registrar's No. 10

FILED SEP 7 1967

VS 300
Rev. 4/59

1 1010

2 8120

3

4 1

5 2

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7 1

8 2

9 8161

10 26

11 101

12 91-3

13 1-1

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <p style="text-align: center; font-size: 18pt;">Shannon</p>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <p style="text-align: center;">Montier</p>		c. CITY OR TOWN <p style="text-align: center;">W. Frankfort</p>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS <p style="text-align: center;">607 E. 7th</p>	
3. NAME OF DECEASED (Type or print) First <u>Ina</u> Middle <u></u> Last <u>Harnes</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/30/1907</u>
9. AGE (last birthday) <u>57 60</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Industry</u>	
11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u></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>961-03-5460</u>		17. INFORMANT <u>Harry Riddle W. Frankfort, Ill</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>Fractured Skull</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u>	
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.		DUE TO (b) _____ 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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Auto accident</u>	
20c. TIME OF INJURY <u>5:00 p.m.</u> Hour <u>7-5-67</u> 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.) <u>on trip only post-mortem</u>		20f. CITY, TOWN, OR LOCATION <u>Montier Shannon Mo.</u>	
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <u>5:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deceased or title) <u>Denton Wilson, M.D. - Coroner</u>	
22b. ADDRESS <u>Eminence, Mo.</u>		22c. DATE SIGNED <u>7-8-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/8/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tower Heights Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>W. Frankfort, Illinois</u>
24. FUNERAL DIRECTOR <u>Union Funeral Home W. Frankfort, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u></u>	
26. REGISTRAR'S SIGNATURE <u>Mabel Green</u>			

USE BLACK INK OR TYPEWRITER RIBBON

SL. 1000 50

SEP 4 1967

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Franklin D. Roosevelt

STATEMENT BY LICENSED EMBALMER

X 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 *Cecil D. Bell*

Licensed Embalmer No. *5368*

P. O. Address *W. View, 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.