

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18150**

FILED JUN 17 1955

BIRTH NO. _____ REG. DIST. NO. **99** PRIMARY REG. DIST. NO. **5372** Registrar's No. **23**

0320

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

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maysville, 4 Mi. N.E. LENGTH OF STAY (in this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maysville 4 Mi. N.E.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If rural, give location) 0320	

3. NAME OF DECEASED (Type or Print)	a. (First) Juanita	b. (Middle) Marie	c. (Last) Harms	4. DATE OF DEATH (Month) (Day) (Year)
				5 21 55

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 1 - 5 1951	9. AGE (in years; last birthday) 4	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Victor Harms	13b. MOTHER'S MAIDEN NAME Gladys Legg	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. XXXXX	17. INFORMANT'S SIGNATURE OR NAME Victor Harms	ADDRESS Maysville Mo
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Polycystic		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Disease of lungs		
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on **May 14, 1955**, and that death occurred at **6:02 AM.**, from the causes and on the date stated above.

23a. SIGNATURE Dr. Harold Parker M.D.	(Degree or title)	23b. ADDRESS Maysville Mo	23c. DATE SIGNED 5/25/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-23-55	24c. NAME OF CEMETERY OR CREMATORY Hopewell	24d. LOCATION (City, town, or county) (State) Maysville Mo.
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DATE REC'D BY LOCAL REG. 6-7-55	REGISTRAR'S SIGNATURE R. Davidson 82-0	25. FUNERAL DIRECTOR'S SIGNATURE John Brown	ADDRESS Maysville Mo
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STATEMENT BY LICENSED EMBALMER

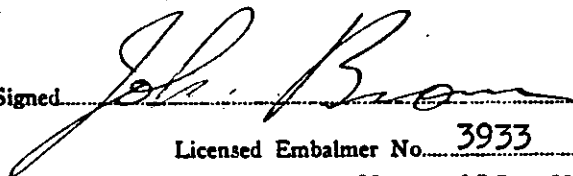
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 3933

P. O. Address Maysville 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 this body is not embalmed, fact should be so stated above.