

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

783-246867

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 420

FILED JAN 2 1964

DO NOT WRITE ON THIS STUB	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED				
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (if outside corporate limits, give TOWNSHIP only) Kirksville		Length of stay in 1b 3 wks.	c. CITY OR TOWN Kirksville
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 903 East Harrison
3. NAME OF DECEASED (Type or print) Olive Pearl Harvey		First Middle Last	4. DATE OF DEATH Dec. 27, 1963
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1914
9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done even if retired) practical nurse	10b. KIND OF BUSINESS OR INDUSTRY practical nurse
11. BIRTHPLACE (City and state or country) Marion, New York	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Mr. & Mrs. Essie Smart,		13b. MOTHER'S MAIDEN NAME foster parents, deceased.	14. NAME OF HUSBAND OR WIFE Guy W. Harvey
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 Mrs. Woodrow Rider, 502 E. Normal, Kirksville, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH 20 MIN
Conditions, if any, which gave rise to above cause (a), stating 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) CHRONIC Hepatitis - cholecystitis - cholelithiasis			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 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 12-1-63 to 12-27-63 and last saw her alive on 12-26-63 Death occurred at 8:09 AM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul Laughlin J. DO		22b. ADDRESS KIRKSVILLE, Mo	22c. DATE SIGNED 12-28-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec 29, 1963	23c. NAME OF CEMETERY OR CREMATORY Maple Hills Cemetery	23d. LOCATION (City, town, or county) (State) Kirksville, Mo.
24. FUNERAL DIRECTOR Do Riley Funeral Home, Inc. 415 North Franklin Kirksville, Missouri	ADDRESS W.K. Jackson Pres	DATE RECD. BY LOCAL REG. Dec 28, 1963	26. REGISTRAR'S SIGNATURE Doris W. Rattiff

USE BLACK INK OR TYPEWRITER RIBBON

JAN 10 1964

Permit issued Dec. 28, 1963

EARL LAUGHLIN, JR., D.D.

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 Wm K Jackson

Licensed Embalmer No. 3954

P. O. Address Ketchumville SMO

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.