

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

35994

1. PLACE OF DEATH
 County Gasper Co Registration District No. 417 File No. _____
 Township _____ Primary Registration District No. 3021 Registered No. 119
 City Webb City (No. Jane Chinnick Park) St. _____ Ward _____

2. FULL NAME Ired Thomas Harvey
 (a) Residence No. Kansas City Mo St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 3, 1895

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
43 3 15

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work clerk
 (b) General nature of industry, business, or establishment in which employed (or employer) Dr. Clethompson
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Thomas Harvey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER Sarah Sumner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown

14. INFORMANT No. Harold Harvey
 (Address) Springfield Mo

15. FILED 10-18-28 J. P. M. Stormont
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-18-28

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1928, to Oct 18, 1928, that I last saw him alive on Oct 15, 1928, and that death occurred, on the date stated above, at 10-30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage
 (duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. S. Shultz, M.D.
10-18-28 (Address) Webb City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL East Lawn Cemetery Springfield Mo DATE OF BURIAL Oct 19 28

20. UNDERTAKER Josephine Co Springfield Mo ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 26 1928

