

Registration District No. 3
Primary Registration District No. 2002

Registrar's No. _____

1. PLACE OF DEATH
(a) County Jasper **3**
(b) City or town _____
(c) Name of hospital or institution: 821 N. John St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

8. (a) PRINT FULL NAME James L. Harvey

8. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color of race White

6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 6 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Verona Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation S. H. Railroad Matron

11. Industry or business _____

MOTHER FATHER
12. Name James L. Harvey
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Mason
15. Birthplace Unknown Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature M. Letitia Harvey

(b) Address Walt City, Mo.

17. (a) Burial (b) Date thereof Jan 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Camp

18. (a) Signature of funeral director Walt City, Mo. Co.

(b) Address Walt City, Mo. 370

19. (a) 1-17-40 (b) Ed D. James
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Walt City
(If outside city or town limits, write "RURAL")
(d) Street No. 916 N. Main St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16th
year 1940 hour 6 minute 20 A.M.

21. I hereby certify that I attended the deceased from Jan 8 - 40
Jan 16, 1940, to _____, 19____;
that I last saw him alive on Jan 8 -, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Edema
Diabetes Duration _____

Due to _____

Due to SA

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. E. James (M. D. or other) _____
Address 311 Miner Bldg Date signed _____

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.

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE 1-28-42

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 myself

....., Registered Apprentice No.

working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 3,922

P. O. Address Webb City, 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, above space should be left blank.