

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 115

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

JOSEPH HARVEY ^{b10}

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race col.

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife

Fulla Harvey

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased

May 16 1864
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

76

-

19

hr.

min.

9. Birthplace

Sturgeon

MO.

10. Usual occupation

Retired - had been laborer

11. Industry or business

MOTHER FATHER

12. Name Louis Harvey

13. Birthplace

Sturgeon

MO.

14. Maiden name

E. Egan

Palmer

15. Birthplace

Sturgeon

MO.

16. (a) Informant's own signature

Harvey Palmer

(b) Address

Moberly, MO.

17. (a)

Burial

(b) Date thereof

June 6 - 40
(Month) (Day) (Year)

(c) Place: burial or cremation

Sturgeon, MO

18. (a) Signature of funeral director

J. C. Carr

(b) Address

Moberly, MO 625

19. (a)

June 6 - 1940

(b)

Leah Williams
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. 110 Wisdom St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4. 40
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 2, 40
to June 4, 40
that I last saw him alive on June 3, 1940
and that death occurred on the date and hour stated above. June 2, 1940

Immediate cause of death

Carcinoma of Bladder 8M
Due to _____

Due to 51

Other conditions (include pregnancy within 8 months of death)

Major findings: Of operations

Of autopsy

Duration

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)

23. Signature J. C. Carr (M. D. or other) _____
Address Moberly, MO Date signed June 4, 40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state CAREFULLY. Information should be carefully supplied.

RECEIVED

District Health Officer No. 10

District File Number 7-40-1472

Date Filed JUL 15 1940

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.....

....., Registered Apprentice No.....
working under personal supervision.

Signed

Robert L. Carr

Licensed Embalmer No. 3190

P. O. Address Moberly Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.