No. 2
4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40995

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4673

48
3
8

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days (Specify whether
In this community 55 Yrs. 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson 048
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2905 Olive
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME James W. Harvey
3. (b) If veteran, name war Yes World War
3. (c) Social Security No. 486-10-7378
4. Sex 0 Male
5. Color or race Wh.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mabel Harvey
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased Jan. (Month) 17 (Day) 1886 (Year)

8. AGE:

Years	Months	Days	If less than one day
55	10	27	hr. min.

9. Birthplace Kansas City (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Truck driver K.C. Power & L
11. Industry or business Light Col
FATHER
12. Name Edward Harvey
13. Birthplace Scotland 4 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Clara Bolen
15. Birthplace Quincy (City, town, or county) Ill. 1 (State or foreign country)
16. (a) Informant Mabel Harvey
(b) Address 2905 Olive
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-41 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington
18. (a) Signature of funeral director Eylar Funeral Home
(b) Address 1800 Linwood K.C. Mo.
19. (a) Dec 16, 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15, 1941,
year hour 8 minute 20 A. M.
21. I hereby certify that I attended the deceased from Dec 1, 1941, 19 , to Dec 15, 1941, 19 ,
that I last saw him alive on Dec 15, 1941, 19 ,
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolus — Duration 5 Minutes
Due to Operation
Due to Appendicitis
Other conditions No — (Include pregnancy within 3 months of death)
Major findings: Of operations Appendicitis
Of autopsy yes

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 no
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature M B Casebolt (M. D. or other) 0
Address 715 Argyle Bldg K. C. Mo Date signed 12-15-41

(Licensed Embalmer's Statement on Reverse Side)

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 my personal supervision.

Signed.....Chas Wilfs

Licensed Embalmer No. 2644

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40995

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Kansas City
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James W. Harvey

3. (b) If veteran name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 17 (Day) 1886 (Year)

8. AGE: Years 55 Months 10 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw h alive on 19;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to 1211	
Due to	
Other conditions Appendicitis (Include pregnancy within 3 months of death)	

Major findings Of operation Appendicitis Catarrhal

Of autopsy Pulmonary Embolus

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature M P Casebolt MD (M. D. or other)

Address 715 Argyle Bldg K.C. Mo. Date signed 1-29-42

FEB 10 1940