

S. No. 2
DM-5-43
v. 5-17-39
I X36571
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DEPARTMENT OF HEALTH OF THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED AUG 30 1946 STANDARD CERTIFICATE OF DEATH

State File No. 222709
Registrar's No. 5725

Registration District No. 251 Primary Registration District No. 3041

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Macon
(c) Name of hospital or institution:
Stiel Hildbrich Orlapadius Sanatorium
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Cook 999
(c) City or town Chicago
(If outside city or town limits, write "RURAL")
(d) Street No. 5-800 Stony Island Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME J.W. Harvon
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Feb 23 1880
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 18
year 1946 hour 2 minute 17 M.
21. I hereby certify that I attended the deceased from August 10, 1946 to August 18, 1946
that I last saw him alive on August 17, 1946
and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 5 Days 25 If less than one day
hr. min.

Immediate cause of death Cerebral Embolism
Due to Chronic Endocarditis & decompensation
Due to _____

9. Birthplace Rockport Co Indiana (City, town, or county) (State or foreign country)
10. Usual occupation General Supt (Retired)
11. Industry or business Illinois Central Ry
12. Name John Harvon
13. Birthplace Rockport Co Indiana (City, town, or county) (State or foreign country)
14. Maiden name Burkhart
15. Birthplace Rockport Co Indiana (City, town, or county) (State or foreign country)

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.

MOTHER FATHER
16. (a) Informant Helen Harvon Thompson
(b) Address 945 7 Winchester Ave
17. (a) removal (b) Date thereof Aug 18 46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt Hope Cemetery
18. (a) Signature of funeral director Delbert Skum
(b) Address Macon Mo
19. (a) Aug 22 46 (b) Ruth McNeely
(Date received local registrar) (Registrar's signature)

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 2
23. Signature Floyd E Gunn (M.D. or other) D.O.
Address Stiel Hildbrich San Date signed 8/18/46

185 (Licensed Embalmer's Statement on Reverse Side)

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

8-29-46

265

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RECEIVED
SEP 9 1946
AUG 30 1946

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 Albert Skinner
Licensed Embalmer No. 751
P. O. Address Macon 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, fact should be so stated above.