

FILED APR 1947

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 63

1. PLACE OF DEATH:

(a) County DeWitt  
(b) City or town Ship, Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution State Hospital No 32  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 yrs 5 months 19 days  
In this community 8 years 5 months 19 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Barton  
(c) City or town Liberal  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. no years.

3. (a) PRINT FULL NAME IVAN R HARVEY

3. (b) If veteran, name war L 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased. 12-28-1914  
(Month) (Day) (Year)

8. AGE: Years 32 Months 2 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Laborer

MOTHER FATHER

12. Name Charles W. Harvey  
13. Birthplace Kansas  
(City, town, or county) (State or foreign country)  
14. Maiden name Carla Shields  
15. Birthplace Lawa  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital record  
(b) Address Liberal, Mo  
17. (a) Removal (b) Date thereof 3-27-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Welfare  
18. (a) Signature of funeral director Welfare  
(b) Address Welfare  
19. (a) 4-4-47 (b) Kathryn Harvey  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27  
year 1947 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from 1-17-47 to 3-27-47, 1947  
that I last saw him alive on 3-27-, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 13B  
Of autopsy \_\_\_\_\_

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? 0

While at work? 0 (Specify type of place) (e) Means of injury MD  
23. Signature R. J. Hall (M.D. or other) MD  
Address Liberal Mo Date signed 3-27-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

OTIS SMITH

108  
100  
10

RECEIVED  
District Health Officer No. 7,  
District File Number 3-47-295  
Date Filed 4-8-47

**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 Otis Smith  
Licensed Embalmer No. 3652  
P. O. Address Mulberry St.

**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.**