

FILED MAY 20 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16750

Registration District No. 47

Primary Registration District No. 57.57

Registrar's No. 173

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Steedman  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rural  
(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 MISSOURI (b) County CALLAWAY  
(c) City or town STEEDMAN  
(If outside city or town limits, write "RURAL")  
(d) Street No. RURAL R.F.D.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EMMA HARVEY

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife W. H. HARVEY 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased JUNE 6 1876  
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 0  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

12. Name WM DAVIS

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

14. Maiden name UNKNOWN

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant W. H. HARVEY

(b) Address STEEDMAN

17. (a) BURIAL (b) Date thereof MAY 8, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HAMS PRAIRIE

18. (a) Signature of funeral director John Y. Mangan

(b) Address 712 Court Fulton, Mo.

19. (a) May 8, 1947 (b) Josie Marschloff  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6  
year 1947 hour 11 minute 30 M.

21. I hereby certify that I attended the deceased from Feb 5 1946 to MAY 8 1947  
that I last saw her alive on May 16 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Essential Hypertension with aneurysm

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

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

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 \_\_\_\_\_

Signature W. O. Payne (M. D. or other) \_\_\_\_\_  
Address 176 S. Fulton Date signed 7/6/47

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Date Filed *5-17-47*

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District File Number

District Health Officer No. 9,

RECEIVED

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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..... *Glen Y. Mauhin*

Licensed Embalmer No..... *2728*

P. O. Address..... *Fulton, W*

**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, fact should be so stated above.**

Registration District No. 47

Primary Registration District No. 5157

Registrar's No. 175-

1. PLACE OF DEATH:

(a) County Callaway  
 (b) City or town Sumner  
(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)

3. (a) PRINT FULL NAME

Emma Harvey

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased June 6 1906  
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days \_\_\_\_\_  
(If less than one day) hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) May 8-1947 (b) Joan Marsichoff  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

FAMILY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

B  
45  
13880

11  
5  
100

110750