

S. No. 2
DM-5-43
v. 5-17-39
I X36871

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30968**
Registrar's No. **843**

FILED OCT 9 1947
128

Registration District No. Primary Registration District No. **5466**

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Rural - S. Camadecur Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **28 days**
(Specify whether
In this community **28 days**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Christian 22**
(c) City or town **Keltner**
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Beverly Jean Harville**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **no**

4. Sex **F** / race **W**
5. Color or race
6. (a) Single, widowed, married, divorced **S O**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased **August 26, 1947**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
— — 28 hr. min.

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

10. Usual occupation **Infant**

11. Industry or business

MOTHER FATHER
12. Name **Gene B. Harville**
13. Birthplace **Keltner, Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Jessie Luetta Morrison**
15. Birthplace **Keltner, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Gene B. Harville**
(b) Address **Keltner, Missouri**

17. (a) **Mount Olive** (b) Date thereof **9-24-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mount Olive Cem.**

18. (a) Signature of funeral director **T. B. Chaffin**
(b) Address **Ozark Mo**

19. (a) **9-23-47** (b) **J. W. Handy**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **9** day **23**
year **1947** hour **5** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **8-26-47**, 19, to **9-23-47**, 19;
that I last saw her alive on **9-22-47**, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death **Congenital heart disease**
(Patent foramen Ovale)
Due to

Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
157K

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 **R. A. Michael** (Date or other)
Address **Springfield Mo** Date signed **9-23-47**

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

900

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..... *T. B. Chaffin*

Licensed Embalmer No. *2192*

P. O. Address..... *Ozark, 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.