

No. 2  
-12-45  
5-17-39  
P1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35297**  
Registrar's No. **108**

Registration District No. **278**  
Primary Registration District No. **3054**

1. PLACE OF DEATH:  
(a) County **Pike**  
(b) City or town **Louisiana**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Pike Co. Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 day**  
(Specify whether  
In this community **60 Years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Pike**  
(c) City or town **Louisiana**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **300 North E St.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **JOHN STERLING HARVEY**  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct.** day **14**  
year **1947** hour **1** minute **05 P.M.**  
21. I hereby certify that I attended the deceased from  
**10-13 1947** to **10-14 1947**  
that I last saw him alive on **10-14-47**  
and that death occurred on the date and hour stated above.

4. Sex **Male**  
5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Margaret H. Harvey**  
6. (c) Age of husband or wife if alive **1974** years  
7. Birth date of deceased **Aug. 19**  
(Month) (Day) (Year)

Immediate cause of death  
**CORONARY OCCLUSION & MYOCARDIAL INFARCTION**  
Duration **3 days**

8. AGE: Years **73** Months **1** Days **25**  
If less than one day hr. min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations **744**  
Of autopsy \_\_\_\_\_

9. Birthplace **Fulton Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Retired Railroad Man**  
**Railroad Bridge Const.**

11. Industry or business \_\_\_\_\_  
12. Name **William H. Harvey**  
13. Birthplace **Unknown Tennessee**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Rose J. Austin**  
15. Birthplace **Unknown Tennessee**  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant **David Harvey**  
(b) Address **Louisiana Missouri**  
17. (a) **Burial** (b) Date thereof **10/16/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Riverview Cem.**  
18. (a) Signature of funeral director **Garner & Sterne**  
(b) Address **Louisiana Missouri**  
19. (a) **10-16-47** (b) **Bernice Collier**  
(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? **(C)**  
While at work? (Specify type of place) \_\_\_\_\_  
(b) Means of injury \_\_\_\_\_  
23. Signature **Z. P. Johnson** (M. D. or other **MD**)  
Address **LOUISIANA, MO.** Date signed **10-16-47**

(Licensed Embalmer's Statement on Reverse Side)

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

3  
2  
1

RECEIVED

District Health Officer No. 10

File Number 11-47-1174

Date Filed NOV - 4 1947

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.....

*Virginia M. Sterne*, Registered Apprentice No. *491*,  
working under my personal supervision.

Signed

*J. B. Sterne*

Licensed Embalmer No. *4039*

P. O. Address *Louisiana, 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.