

FILED AUG 18 1948  
Registration District No. **278**

Primary Registration District No. **4552**

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

114

1. PLACE OF DEATH:  
(a) County **Wright**  
(b) City or town **Mountain Grove**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **G**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **Life**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Wright** **114**  
(c) City or town **Mountain Grove**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Walter Harvey**  
3. (b) If veteran, name war  
3. (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **June** day **22nd**  
year **1948** hour **7** minute **30** P. M.

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Emeda Harvey**  
6. (c) Age of husband or wife if alive **75** years  
7. Birth date of deceased **December 25th 1872**  
(Month) (Day) (Year)

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

8. AGE:	Years	Months	Days	If less than one day
	<b>75</b>	<b>5</b>	<b>27</b>	hr. min.

Immediate cause of death: **Cerebral Apoplexy**  
Due to: **Died before Medical Aid could be obtained**

9. Birthplace **Texas County Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Farmer (retired)**

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

11. Industry or business  
12. Name **Unknown**  
13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **UNK TOWN**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs Emeda Harvey**  
(b) Address **Mountain Grove, Mo**  
17. (a) **Burial** (b) Date thereof **6/24/48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Hillcrest Cemetery**  
18. (a) Signature of funeral director **Gary Stapp**  
(b) Address **Mountain Grove, Missouri**  
19. (a) **S-10-48** (b) **A.B. Ames**  
(Date received local registrar) (Registrar's signature) **348**

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? \_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (or Means of injury) **3**  
23. Signature **Gary Stapp**  
Address **Mountain Grove, Mo** Date signed **6/22/48**

RECEIVED

District Health Officer No. 6;

District File Number 848-945-

Date Filed AUG 17 1948

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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 \_\_\_\_\_

Licensed Embalmer No. 3161

P. O. Address Mt. Pleasant

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.