

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

65-023144

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 94

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0275

2 0450

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4 0

5 1

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9 582.0H

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12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>		Length of stay in lb <u>32 days</u>	c. CITY OR TOWN <u>Franklin</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>A.</u> Last <u>HARVEY</u>			4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1965</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1892</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Line</u>	11. BIRTHPLACE (City and state or country) <u>Saline County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>James T. Harvey</u>	
13b. MOTHER'S MAIDEN NAME <u>Delia Smith</u>		14. NAME OF HUSBAND OR WIFE <u>May D. Craycraft</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. May D. Harvey Franklin, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PANCREATITIS WITH ASSOCIATED SUBPHRENIC ABSCESS</u> <u>ASSOCIATED WITH OBSTRUCTIVE JAUNDICE</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ALSO METASTATIC CARCINOMATOSIS</u> <u>CHOLECYSTECTOMY 5/11/65; CA PROSTATE; CHRONIC NEPHRITIS.</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>6/6/65</u> to <u>6/11/65</u> and last saw ^{her} him alive on <u>6/11/65</u> Death occurred at <u>11:55 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>329 Hawth St. Bronaugh Mo</u>	
22c. DATE SIGNED <u>6/14/65</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>June 15, 1965</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery</u>	
23d. LOCATION (City, town, or county) <u>New Franklin, Missouri</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Markland Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>6/14/65</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		27. (State)	

USE BLACK INK OR TYPEWRITER RIBBON

JUN 22 1965

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Tom D. Marbland

Licensed Embalmer No. 4592

P. O. Address New Franklin, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.