

FILED APR 17 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

11518

1. PLACE OF DEATH

County LawrenceRegistration District No. 467Township LawrencePrimary Registration District No. 4280City Lawrence, Mo.(No. 11)W. Coffield

St. _____ Ward)

2. FULL NAME William Harvotte ?(a) Residence, No. 1120 Coffield St. 0 Ward. _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. ~~SINGLE~~-MARRIED, ~~WIDOWED~~ OR ~~DIVORCED~~ (circle one)

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OFMartha Harvotte6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 12 - 1861

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.68838. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.Farmer10. Date deceased last worked at
this occupation (month and
year) _____11. Total time (years)
spent in this
occupation _____12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Green County, Mo.

13. NAME

Mr. W. Harvotte14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) unknown ?

15. MAIDEN NAME

Martha Richman16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

17. INFORMANT

(ADDRESS)

John Harvotte

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Camp Ground

DATE

March 17 - 1940

19. UNDERTAKER

(ADDRESS)

Anna's funeral home

20. FILED

3-17 1940W. Coffield

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 15 194022. I HEREBY CERTIFY, That I attended deceased from
February 29 1940 to March 15 1940I last saw him alive on March 15 1940 Death is saidto have occurred on the date stated above, at 5:50 PM.

The principal cause of death and related causes of importance were as follows:

Acute Myocardial
Failure with Cardiac
decompensation

Date of onset

2/15/40Other contributory causes of importance: 6 yrsName of operation None Date of _____What test confirmed diagnosis Chemical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Dr. Hugh L. Felsky M. D.(Address) 6 E. Locust St.Lawrence, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

Health Officer No. 6,

Member 440-1107

Date Filed APR 1 1 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 11573
Registrar's No. 18-

Registration District No. 467

Primary Registration District No. 4280

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

1. PLACE OF DEATH

(a) County Lawrence

(b) City or town Laura
(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 William Garoutte

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 3

If less than one day _____ h. _____ 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 unknown (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-17-40 (b) R.W. Cowan M.D. (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) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 15 year 1940 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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 Kenneth T. Kelsey (M. D. or other) _____
Address Lawrence _____ Date signed _____

11573 (1940)