

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024366

Registration District No. 149 Primary Registration District No. 002 Registrar's No. 3573 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300
Rev. 4/59

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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 Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 3 Days	c. CITY OR TOWN Moberly Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 716 South Moulton Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM JOHN HARVEY			4. DATE OF DEATH Month Day Year June 21, 1963
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-12-08
9. AGE (last birthday) 55 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Armstrong, Missouri
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Frank Harvey	
13b. MOTHER'S MAIDEN NAME Mary Nellie Reed		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. VA Hospital Official Records	
17. INFORMANT VA Hospital Official Records		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) CARCINOMA, MOUTH AND TONGUE WITH CERVICAL METASTASES.			INTERVAL BETWEEN ONSET AND DEATH 8 Mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)		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 type="checkbox"/> NO <input checked="" 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 Month, Day, Year s.m. 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 STATE
21. <input checked="" type="checkbox"/> attended the deceased from: June 18, 1963 to June 21, 1963		Death occurred at: 7:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <i>Harry H. Knauff</i> M.D. Knauff		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 6-21-63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JUNE 24, 63	23c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY	23d. LOCATION (City, town, or county) (State) MOBERLY, MISSOURI
24. FUNERAL DIRECTOR <i>Edward E. Robinson</i>	25. DATE RECD. BY LOCAL REG. 6-26-63	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>	

USE BLACK INK OR TYPEWRITER RIBBON

Name of Deceased _____
 Residence _____
 City _____
 State _____
 Date of Death _____
 Cause of Death _____
 Place of Death _____
 Name of Embalmer _____
 License No. _____
 Date of Embalming _____
 Place of Embalming _____
 Name of Student Embalmer _____
 License No. _____
 Date of Embalming _____
 Place of Embalming _____

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STATEMENT BY LICENSED EMBALMER

0-2P

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 Edward E. Robinson

Licensed Embalmer No. 4999

P. O. Address Hannibal, 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.

30-12-0