WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (No. 4964 Genevieve St.; 27 Ward)

Registration District No. 781 File No. 30985

Primary Registration District No. 1003 Registered No. 8932

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John F. Harley.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Jan 23, 1852 (Month) (Day) (Year)

7 AGE: 66 yrs. 8 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: Laborer 121

(b) General nature of industry, business, or establishment in which employed (or employer): Commerce 121

9 BIRTHPLACE (City or town, State or foreign country): Mo

PARENTS

10 NAME OF FATHER: John F Harley

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): England.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara M. Costello

(Address) 4964 Genevieve Ave

15 Filed SEP 26 1918, 191 Marc C. Starkoff Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 24th 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191..... and that death occurred, on the date stated above, at 5-10 a. m.

The CAUSE OF DEATH* was as follows:

1 Acute General Peritonitis

2 Intestinal obstruction from Chronic appendicitis

Adhesions (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 117

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Farth M. D.

9/26, 1918 (Address) Deputy Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence 4964 Genevieve Ave

19 PLACE OF BURIAL OR REMOVAL: Fee Fee Cem. DATE OF BURIAL: Sept 27, 1918

20 UNDERTAKER: Mullen Hudl & Kimmel ADDRESS: 4064 Olive

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

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from .....191....., to.....191.....

that I last saw h.....alive on.....191.....

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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