

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

Do not use this space.

10556

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Raw Primary Registration District No. 1002 Registered No. 111550
 City Kansas City (No. Rochester and Montgal Railway Crossing) Ward _____

2. FULL NAME

(a) Residence. No. 31 Bigelow Park, St. Ward. 10
 (Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Albany Mrs Minnie Harvey.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 25 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
43. 2. 6.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Building Workman.
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

10. NAME OF FATHER Geo Foster Harvey.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Savannah Ga.

12. MAIDEN NAME OF MOTHER Josephine Fiske.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) New York.

14. INFORMANT Mrs Minnie Harvey
 (Address) 31 Bigelow

15. FILED 3/3 1929 M. M. Croome REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Friday March 1 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

accidental Rail Road Locomotive
2072 (duration) yrs. mos. da. 235

CONTRIBUTORY (SECONDARY) Rail run by Mrs. Pacific
Train (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

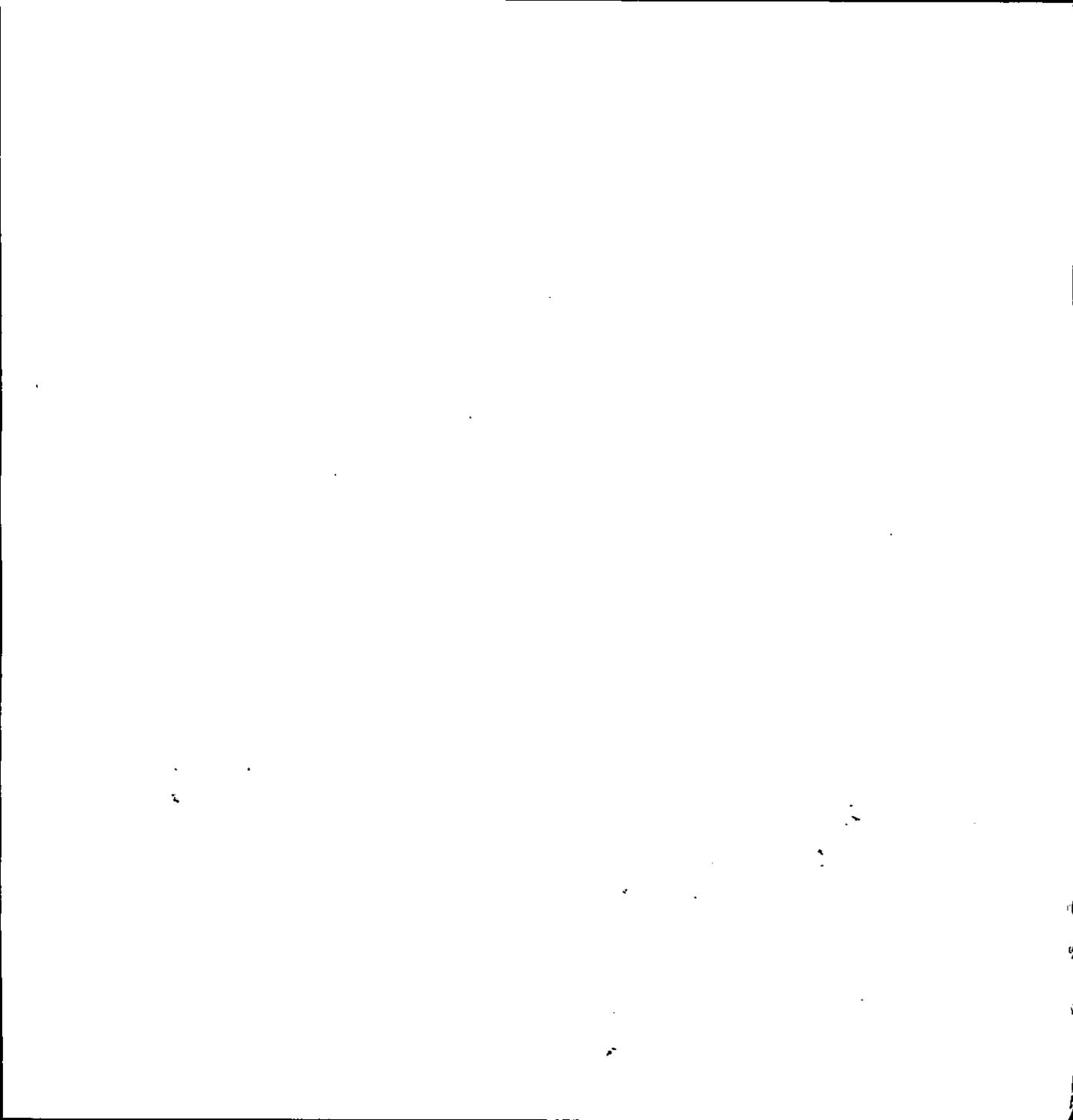
20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Histology, Infection
 (Signed) Stanley G. Stacy, M. D.
3/1 1929 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ednwood. DATE OF BURIAL Mar 4 1929

20. UNDERTAKER Elyar Funeral Home ADDRESS 1800 Linwood



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City *St. City* (No.....)

Registration District No. *399*
Primary Registration District No. *1002*

File No.....
Registered No. *1057*
St. Ward)

2. FULL NAME

Charles Henry Harvey

(a) Residence. No..... St., 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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *M*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

10. NAME OF FATHER.....
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER.....
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT (Address).....

15. FILED *3/3* 19*29* *M. M. Crowe* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 1* 19*29*

17. I HEREBY CERTIFY That I attended deceased from 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Accidental, Rail Road
Traumatism*

CONTRIBUTORY (SECONDARY) *The auto mobile involved*
(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL..... 19.....

20. UNDERTAKER..... ADDRESS.....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-10556

Handwritten text, possibly a signature or date, oriented vertically.