

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

Do not use this space.

28811

1. PLACE OF DEATH

County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 603.3B.
 City Wellston (No. 1229, Greenfield Place) St. _____ Ward _____

File No. _____
 Registered No. 213-2

2. FULL NAME

Charles L. Harvey
 (a) Residence. No. 5330 Pershing Ave. 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8th

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
87 11 6

8. OCCUPATION OF DECEASED Retired
 (a) Trade, profession, or particular kind of work. Soliciting
 (b) General nature of industry, business, or establishment in which employed (or employer) Freight Agent
M. O. P. R.
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Campbell Co. Va.
 (STATE OR COUNTRY)

10. NAME OF FATHER Thomas H. Harvey

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

12. MAIDEN NAME OF MOTHER Lucy Jane Hunter

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

14. INFORMANT Mrs J. P. Higgins
 (Address) 5330 Pershing Ave

15. FILED 8/16 19 27 Wally Bruce REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 14th 19 29

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1929 to Aug 14 1929
 that I last saw him alive on Aug 13 1929, and that death occurred, on the date stated above, at 2 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dysentery
 (duration) yrs. mos. ds. 5

CONTRIBUTORY (SECONDARY) Swelling and abdominal tumor
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH At his home

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. M. Patton, M. D.

8/15 1929 (Address) 5849 Maple Dr.

*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 Woodsbury, Mo. DATE OF BURIAL August 16th 19 29

20. UNDERTAKER C. B. Lupton ADDRESS 4949 Olive St.

CAUSE OF DEATH. PHYSICIANS should state cause of OCCUPATION is very important.

bl...
omi...

Dr. Patton - 5849 Maple Ave
Evanston, Ill 4330

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

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1. PLACE OF DEATH
 County St. Louis Registration District No. 489
 Township Central Primary Registration District No. 6033 File No. _____
 City _____ (No. _____ St. _____ Ward _____) Registered No. 252

2. FULL NAME Charles E. Harvey
 (a) Residence. No. _____ St. _____ Word _____
 (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) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8 1841

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>87</u>	<u>11</u>	<u>6</u>		

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 8/16, 19 29 Greta Bray, M.D.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 14 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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Systolic
 _____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Senility & Abdominal tumor (Pneumonia)
 _____ (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, 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

WRITE PLAINLY, WITH UNFADING INK. --- THIS IS AN AFFIRMATION RECORD ---
 N. B.—Every item of information should be fully supplied. Physicians should state to be stated EXACTLY. PHYSICIANS should state to be stated EXACTLY. PHYSICIANS should state to be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUTION should be exercised in the classification of the cause of death. REGISTERED CHARLES HARVEY RECEIVED A FEE FOR COMMUNICATIONS LEVEL VERY ARE COMPLETE AS PRESCRIBED BY LAW

11-228 (B) - 5

Requested to make copy of _____
dated by check marks, lacking from the death certificate:

Name: Charles C. Harvey
Who died at: St. Louis Mo., on Aug. 14, 1929.

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Dysentery

Contributory: Senility and abdominal tumor (malignant) (primary seat unknown)

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

11886(2) -5