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

Do not use this space.

1. PLACE OF DEATH
County Jackson
Township Main
City K C Mo (No. 1323 Bellefountain St. Ward)
Registration District No.
Primary Registration District No.

File No. 1355
Registered No. 186

2. FULL NAME David T. Harvey
(a) Residence. No. 1323 Bellefountain St. Ward 12
(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 Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 24 1866

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
64	0	21	

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

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

PARENTS
10. NAME OF FATHER Samuel Harvey
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) W Va
12. MAIDEN NAME OF MOTHER no record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no record

14. INFORMANT Ella Harvey
(Address) 1323 Bellefountain K C Mo

15. FILED Jan 14, 1931 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1931, to Jan. 13, 1931, that I last saw him alive on Jan 13, 1931, and that death occurred, on the date stated above, at 12 Noon m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Pulmonary Oedema & Cardiac Failure
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (SECONDARY) Hypertension
(duration) 15 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination
(Signed) Marvin R. Biles, M. D.
1/14, 1931 (Address) 1424 Professional Bl.

*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 Mt. Moriah
DATE OF BURIAL Jan 15 1931

20. UNDERTAKER Mrs. C. L. Forster
ADDRESS K. C. 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.

WITH UNFADING INK—THIS IS A PERMANENT RECORD