

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

Do not use this space.

1703

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 602 W. 39)

Registration District No. 299
Primary Registration District No. 1002

File No. 100
Registered No. 100
St. _____ Ward _____

2. FULL NAME Nathan J. Harvey

(a) Residence, No. 602 W. 39 St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 56 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) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 12, 1854
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 10 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Butcher
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 262
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 2 1/2

12. BIRTHPLACE (CITY OR TOWN) Crawfordsville (STATE OR COUNTRY) Indiana

13. NAME William Harvey

14. BIRTHPLACE (CITY OR TOWN) Virginia (STATE OR COUNTRY)

15. MAIDEN NAME Eliza J. Wilson

16. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY)

17. INFORMANT Miss Lottie Harvey (ADDRESS) 602 W. 39

18. BURIAL, CREMATION, OR REMOVAL PLACE Elmwood DATE Jan 28 1937

19. UNDERTAKER D. W. Newcomer's Sons (ADDRESS)

20. FILED Jan 28 1937 M. M. Crowne Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 27, 1937

22. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1937, to Jan 27, 1937. I last saw him alive on Jan 26, 1937. Death is said to have occurred on the date stated above, at 5:30 A. M.

The principal cause of death and related causes of importance were as follows:

Senility
Arteriosclerosis
Date of onset ?

Other contributory causes of importance 100%

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____ (Signed) E. C. Carrier, M. D.

(Address) 1722 W. 31st, H.C., Mo.

Ua 3434

1-4130

JAN 10 1956

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. St. Ward)

File No. 494
Registered No.

2. FULL NAME

Nathan J. Harvey

(a) Residence, No. 602 N. 39th 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

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

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

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

19. UNDERTAKER (ADDRESS)

20. FILED 1/28 19 Mr. M. Groves Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-27-37

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Senility
Bronchitis, tubercle

Date of onset

Other contributory causes of importance:

106a

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) E. C. Carter, M. D.
(Address)

JAN 10 1950

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