

SEP 25 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6889

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 56 days
(Specify whether years, months or days)

In this community 23 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4544 Garfield
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John Harvey 1 11

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 12
year 1940 hour 2 minute 40 A. M.

4. Sex Male 5. Color or race Colored

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rosa Harvey

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased 6 1887
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-18- 19 40 to 8-12- 19 40,
that I last saw him alive on 8-12- 19 40,
and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 7 Days 6 If less than one day _____ hr. _____ min.

Immediate cause of death Urethral Stricture with Urinary Retention Approx. 1 Yr.
Due to Non malignancy
Uremia (Postoperative) " 48 Hours

9. Birthplace OKLAHOMA Missi
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business None

MOTHER FATHER { 12. Name Peter Harvey

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Harvey Wheeler

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

Other conditions 1360
(Include pregnancy within 3 months of death)

Major findings: As above

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Elva Clark

(b) Address 4544 Garfield

17. (a) Burial (b) Date thereof 8-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Mary Wade

(b) Address 4202 Finney Ave

19. AUG 14 1940 (b) J. P. Bredbeck
(Date received local registrar) (Signature of Registrar)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. Fletcher (M. D. or other) 8-12-40
Address 2601 N. Whittier St. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____ working under my personal supervision.

Signed

S J Watson

Licensed Embalmer No. *2698*

P. O. Address *2769 Chantrel*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.