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7-5-17-39
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23223
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5219**
1856
Registrar's No.

FILED MAR 6 1944 8
Registration District No.

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether _____)
In this community _____
years, months or days)

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. 2359a S. 9th St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clarence C. Harvey

3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lou Allie Harvey 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased May 13, 1897
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 9 9 _____ hr. _____ min.

9. Birthplace Paris Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance Man

11. Industry or business _____

MOTHER FATHER { 12. Name Henry G. Harvey
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Dora Pruett
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Allie Harvey

(b) Address 2359a S. 9th St.

17. (a) Burial (b) Date thereof 2/25/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cm.

18. (a) Signature of funeral director Weich Bros.

(b) Address 220 S. Grand

19. (a) FEB 24 1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 22nd
year 1944 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from Feb. 19th
1944 to Feb. 22nd, 1944.
that I last saw him alive on Feb. 22nd, 1944.

and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (left lung)
Pneumonia (lobar) Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

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 [Signature] (M. D. or other) _____

Address 1515 Lafayette Date 2/23/44

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

Dary A. Stewart

Licensed Embalmer No. 3722

P. O. Address. 412 Duchouquette St.

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, fact should be so stated above.