

FILED DEC 9 1944 318

Registration District No. \_\_\_\_\_

1003

Registrar's No. 10285

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(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:  
HOMER G. PHILLIPS  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 24 HOURS  
(Specify whether  
In this community 14 YEARS  
years, months or days)

3. (a) PRINT FULL NAME TOMMIE LEE HARVEY

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

4. Sex MALE 5. Color or race COLORED 6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased APRIL 5 1905  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
39 ~~38~~ 7 16 hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation LABOR.

11. Industry or business NONE.

MOTHER FATHER { 12. Name SAM HARVEY  
13. Birthplace MISS. (City, town, or county) (State or foreign country)  
14. Maiden name ANNA PRICE  
15. Birthplace MISS. (City, town, or county) (State or foreign country)

16. (a) Informant Uonel Harvey

(b) Address 4449 Garfield

17. (a) Burial (b) Date thereof Dec. 4 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK.

18. (a) Signature of funeral director Boyd Bros. Funeral Home

(b) Address 3704 Linnway Ave.

19. (a) DEC 3 1944 (b) J. T. Brideck  
(Date received local registrar) (Registrar's signature)

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. 44 49 Garfield  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 1, year 1944 hour 1 minute 32 A.M.

21. I hereby certify that I attended the deceased from November 29, 1944, to December 1, 1944 that I last saw him in alive on December 1, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia (Autopsy) Duration 2 days

Due to Infected incised wound middle finger of right hand 6 weeks

Due to Removal of bone from finger with infection developed

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

23. Signature Alvin Moore (M.D. or other) \_\_\_\_\_  
Address 2601 W. Webster Date signed 12/6/44

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

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.....

William C. McDowell....., Registered Apprentice No.....  
working under my personal supervision.

Signed William C. McDowell.....

Licensed Embalmer No. 2114.....

P. O. Address.....

**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.)**

**2 If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10285

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Jimmie J. Harvey

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased April 5  
(Month) (Day) (Year)

8. AGE: 39 Years 2 Months 3 Days If less than one day \_\_\_\_\_ min.

9. Birthplace Keokuk, Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) DEC 18 1944 (b) J. F. Bredeek  
(Date received local records) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
(Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

35948