

No. 2  
4-5-43  
5-17-39  
I X36871

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38070

FILED NOV 24 1947  
Registration District No. 49

Primary Registration District No. 1002

State File No. \_\_\_\_\_  
Registrar's No. 4754

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Menorah Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 days  
In this community 1516 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME HARVEY MICHAEL COMER

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) single widowed, married, divorced, infant

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

7. Birth date of deceased Oct. 28, 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 16 15 hr. min.

9. Birthplace Kansas City, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation infant

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

MOTHER, FATHER

12. Name Harvey W. Comer

13. Birthplace Alba, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Grace E. Johnson

15. Birthplace Independence, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Harvey W. Comer

(b) Address 1308 Cedar, K. C. 3, Mo.

17. (a) burial (b) Date thereof 11/15/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director: Robt. Carson  
(b) Address Independence, Mo.

19. (a) 11-14-47 (b) Waldeline Holman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1308 Cedar  
(If rural, give location) no  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 13  
year 1947 hour 12 minute from M.

21. I hereby certify that I attended the deceased from 7:00 PM  
10-12 1947 to 11-13 1947

that I last saw h. M. alive on 11-13 and that death occurred on the date and hour stated above.

Immediate cause of death Acute GASTRO-ENTERITIS - non-specific  
Duration \_\_\_\_\_

Due to Asystole (aspiration of gastric contents)

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy As Above  
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 0

23. Signature Sidney P. Parula (M. D. or other) \_\_\_\_\_  
Address 628 Park Blvd Date signed 11/14

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

*Mr. J. Parkula  
Emp. of City*

**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 *Gloyd C. Carson*

Licensed Embalmer No. *4199*

P. O. Address *Indip. Mo.*

**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.