

No. 300
10.48

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6255
State File No. 1219
Registrar's No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1219			
1. PLACE OF DEATH a. COUNTY <u>St. Louis Mo.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>STO</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>1701 N Taylor Ave. St. Louis</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		17 7 0			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1701 N Taylor Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>1701 N Taylor Ave.</u>					
3. NAME OF DECEASED a. (First) <u>Charles</u> (Type or Print)			b. (Middle) <u>Harvey.</u>		c. (Last)				
4. DATE OF DEATH <u>Feb. 6 1949</u>			5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		
8. DATE OF BIRTH <u>about</u>			9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (If we kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Okolona Miss</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Peter Harvey</u>			13b. MOTHER'S MAIDEN NAME <u>Harriett Wheeler</u>			14. NAME OF HUSBAND OR WIFE <u>Adine Harvey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>489 20 8474</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Adine Harvey</u>			ADDRESS <u>1701 N Taylor Ave.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Accident</u> ANTECEDENT CAUSES <u>Peripherical Vascular Disease</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>per</u> DUE TO (c) <u>30</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH. <u>immediate</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>30</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>2 A.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>William H. Sieder, M.D.</u>			23b. ADDRESS <u>4503 Page</u>			23c. DATE SIGNED <u>2/7/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2/8/1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Okolona Miss</u>		24d. LOCATION (City, town, or county) (State) <u>Okolona, Miss.</u>			
DATE REC'D. BY LOSS <u>FEB 8</u>		REGISTRAR'S SIGNATURE <u>J. B. Lazator</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Herman J Smith Funeral Home 4247 W. Labadie</u>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Lawrence T. Watson

Signed.....

Student Embalmer

Licensed Embalmer No. *434*

P. O. Address *1907 South Street*

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.