

FILED DEC 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43159

State File No. _____

REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3069**

Registrar's No. **U4662**

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 3069		Registrar's No. U4662	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give town) Richmond Heights		c. LENGTH OF STAY (in this place) 48		c. CITY (If outside corporate limits, write RURAL and give township) Richmond Heights		d. STREET ADDRESS (If rural, give location) 1227 Sunset A. ve.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1227 Sunset Avenue				d. STREET ADDRESS (If rural, give location) 1227 Sunset A. ve.			
3. NAME OF DECEASED a. (First) Harvey			b. (Middle) F.			c. (Last) Cleveland	
4. DATE OF DEATH (Month) (Day) (Year) Dec. 10 1949							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan 23 1882	
9. AGE (In years last birthday) 67		10. MONTHS 67		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory			11. BIRTHPLACE (State or foreign country) Indiana	
13a. FATHER'S NAME William David			13b. MOTHER'S MAIDEN NAME Olive Skelton			14. NAME OF HUSBAND OR WIFE Beatrice B. Cleveland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Beatrice B. Cleveland 1227 Sunset Ave.			
18. DATE 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, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Hemorrhage, Hypertension					INTERVAL BETWEEN ONSET AND DEATH 4 wks
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage					2 mo
		DUE TO (c) Gen. Arteriosclerosis					10 yrs
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					331X
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X					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 JULY 1948 , to 10 DEC 1949 , that I last saw the deceased alive on 10 DEC 1949 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Richard H. Hay, M.D.				23b. ADDRESS 5930 Southwist Ave		23c. DATE SIGNED 11 Dec 49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE Dec. 13, 1949		24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL DEC 12 1949		REGISTRAR'S SIGNATURE Herbert B. Dombke, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister Colonial Mortuary 6164 Chippewa St.			

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.

Student
Student Embalmer

Signed *Harry J. Schumacher*.....

Licensed Embalmer No. *2679*.....

P. O. Address *7814 Broadway*.....

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.