

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42809

State File No.

FILED JAN 12 1956

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 531 Registrar's No. 2985

1. PLACE OF DEATH a. COUNTY <u>ST. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>ST. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN <u>University City</u>		c. CITY OR TOWN <u>4336 University City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6356 WASHINGTON.</u>		e. STREET ADDRESS (If rural, give location) <u>6356 Washington</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>Benson</u>	c. (Last) <u>Harvey</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 21 1955</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Not married</u>	8. DATE OF BIRTH <u>Nov 8, 1948</u>	9. AGE (In years last birthday) <u>7</u>	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 HR. Hours	# UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>Thomas B Harvey</u>	13b. MOTHER'S MAIDEN NAME <u>Helen Durham</u>	14. NAME OF HUSBAND OR WIFE <u>NONE.</u>
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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>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Thomas B Harvey</u> ADDRESS <u>6356 Washington</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain Tumor</u> (b) <u>Pontine</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>0</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>237x</u>
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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?
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22. I hereby certify that I attended the deceased from Nov 8, 1948, to Dec 21, 1955, that I last saw the deceased alive on Dec 5, 1955, and that death occurred at 5:25 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dorothy L. Jones, M.D.</u> (Degree or title)	23b. ADDRESS <u>110 So Central Clayton</u>	23c. DATE SIGNED <u>12/21/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>12/22/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kirkwood, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>12-21-55</u>	REGISTRAR'S SIGNATURE <u>Hebe R. Ambrose</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Lupton + Sons</u> ADDRESS <u>7233 Delmar.</u>
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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.....
Signature of Student Embalmer

Signed..... *Arnold W. Schoene*.....

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.