

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1361

State File No. \_\_\_\_\_  
Registrar's No. **54**

FILED JAN 25 1956

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>				b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Kansas City</b> )		c. LENGTH OF STAY (in this place) <b>7 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		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 <b>Home 3215 Euclid</b>				STREET ADDRESS (If rural, give location) <b>54 3215 Euclid</b>				<b>354<sup>4</sup> 30</b>	
3. NAME OF DECEASED (Type or Print) <b>SAMUEL L. HARVEY</b>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH <b>1 4 56</b>		(Month)		(Day)		(Year)			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, 3 WIDOWED, DIVORCED (Specify) <b>Divorced</b>		8. DATE OF BIRTH <b>10-10-1893</b>			
9. AGE (in years last birthday) <b>62</b>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clark</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bank Commerce Trust Co.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Omaha, Nebraska</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13a. FATHER'S NAME <b>William Harvey</b>		13b. MOTHER'S MAIDEN NAME <b>Nora Alters</b>			
14. NAME OF HUSBAND OR WIFE <b>Marie Harvey</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>505-10-9788</b>			
17. INFORMANT'S SIGNATURE OR NAME <b>Samuel E. Harvey Jr.</b>				ADDRESS <b>4525 N. Bales</b>					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Shots + Hemorrhage resulting from gunshot wounds of chest wall</b> DUE TO (b) <b>Left arm</b> DUE TO (c) <b>Left arm</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <b>89190</b> <b>19</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Kansas City Jackson Miss</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>1-4-56 9:35</b>			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Apparently gunshot wound off</b>							
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE <b>Geo. C. Kealhofer</b> (Degree or title) <b>3</b>				23b. ADDRESS <b>6627 Brook St. Omaha</b>		23c. DATE SIGNED <b>1-5-56</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1-5-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Omaha Nebraska</b>		24d. LOCATION (City, town, or county) (State) <b>Omaha Nebraska</b>			
DATE REC'D BY LOCAL REG. <b>1-6-56</b>		REGISTRAR'S SIGNATURE <b>Neva Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Melody McGilley-Bylar 1800 E. Linwood</b>					

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

JAN 25 1953

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
MEMPHIS, TENNESSEE

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 *Melvin Partee*.....

Licensed Embalmer No. *49*  
P. O. Address *KCT*.....

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.