

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026728

IC-20468247 SL 20260

FILED VS JUL 3 0 1959

2 6802

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO.		Length of stay in 1b 31 DAYS	c. CITY OR TOWN SPRINGFIELD
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 904 S 18TH STREET
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	CHARLES	E.	HARVELL	JULY 18, 1959			

5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/14/93	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	---------------------------	------------------------	-------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) DECATUR, ILLINOIS	12. CITIZEN OF WHAT COUNTRY USA
---	---	--	---

13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME KATIE JOHNSON	14. NAME OF HUSBAND OR WIFE KATHERINE HARVELL
--------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I	16. SOCIAL SECURITY NO. 33 00 55629	17. INFORMANT Address VA HOSP RECORDS 915 N GRAND ST LOUIS MO
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE WITH ANURIA	2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) CARCINOMA OF ESOPHAGUS	3 MONTHS
DUE TO (c) - 150X	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--	--

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
---------------------------------------	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
--	--	------------------------------	--------	-------

21. attended the deceased from **6-17-59**, to **7-18-59** and last saw him alive on **7-18-59**
Death occurred at **9:10 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Sandford Wolfson</i> SANDFORD WOLFSON M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 7-19-59
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/21/59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Springfield, Illinois
---	-----------------------------	------------------------------------	---

24. FUNERAL DIRECTOR G. Wade Granberry	ADDRESS 4202 Finney Ave.	25. DATE RECD. BY LOCAL REG. JUL 21 1959	26. REGISTRAR'S SIGNATURE <i>Earl Smith</i> Earl Smith, M.D.
--	------------------------------------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edward G. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney A

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.