

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-039801**

FILED **NOV 1960** District No. **318** Primary Registration District No. **1003** Registrar's No. **10278**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1802 Cole Street</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Hulet</b> Middle <b>Harvey</b> Last <b>Harvey</b>				4. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-2-1900</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b>	IF UNDER 24 HR Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Jerry Harvey</b>			13b. MOTHER'S MAIDEN NAME <b>Eilpha Lewis</b>			14. NAME OF HUSBAND OR WIFE <b>Carrie Harvey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT <b>Carrie Harvey</b>		Address <b>1802 Cole Street</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Encephalopathy with Contussion and Laceration of Scalp</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b> <b>7 1/2 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pemphigus Vulgaris, Aspiration Pneumonia</b>						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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	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. I attended the deceased from <b>8-8-60</b> to <b>10-20-60</b> and last saw <del>her</del> <sup>him</sup> alive on <b>10-20-60</b> Death occurred at <b>10:40</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Edward B. Whittier M.D.</i> (Degree or title)				22b. ADDRESS <b>2601 N. Whittier St.</b>		22c. DATE SIGNED <b>10-22-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-26-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson</b>		23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri</b>			
24. FUNERAL DIRECTOR <b>Ellis Funeral Home, 2820 Stoddard St.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>OCT 24 1960</b>	26. REGISTRAR'S SIGNATURE <i>Coal Smith</i>		

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 Fullan E. Culter

Licensed Embalmer No. 4198  
P. O. Address Adrian

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.