

1. PLACE OF DEATH
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Mo.** Length of stay in 1b
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Enroute City Hospital** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Missouri**. b. COUNTY
 c. CITY OR TOWN **St. Louis** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **3225 Montgomery** Residence on Farm Yes No

3. NAME OF DECEASED (Type or print) First **Jackson** Middle **F.** Last **Harvey** 4. DATE OF DEATH Month **June** Day **5** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **About 1890** 9. AGE (last birthday) **71?** IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired** 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) **Missouri** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Unknown** 13b. MOTHER'S MAIDEN NAME **Unknown** 14. NAME OF HUSBAND OR WIFE **Cora Viola**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **Unknown** 17. INFORMANT Address **Oscar Schaefer Public Adm, Civil Cts. Bldg.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Status Asthmaticus;**
 DUE TO (b) **Arterio Sclerosis.**
 DUE TO (c) **241x**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 _____ and last saw her/him alive on _____
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Deputy** 22b. ADDRESS **1300 Clark** 22c. DATE SIGNED **6-20-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **6-21-61** 23c. NAME OF CEMETERY OR CREMATORY **St. Matthews Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Albert H. Hoppe Inc., 4700 Washington, Blvd.** 25. DATE RECD. BY LOCAL REG. **JUN 20 1961** 26. REGISTRAR'S SIGNATURE **Paul Smith, M.D.**

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

[Handwritten Signature]

Licensed Embalmer No. _____
[Handwritten Signature]

P. O. Address _____

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.