

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34885**  
Regist'ar's No. **8672**

FILED OCT 21 1950

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. <b>1003</b>		Regist'ar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>30 YRS.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS</b>		<b>2269</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>				d. STREET ADDRESS (If rural, give location) <b>26 3516 N. 9 St.</b>					
3. NAME OF DECEASED (Type or Print) <b>Cyrus</b>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH <b>Oct 11 1950</b>		(Month)		(Day)		(Year)			
5. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>AUG. 13, 1870</b>		9. AGE (In years last birthday) <b>80</b> if under 1 year: Months _____ Days _____ if under 1 month: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHAPER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>PLANING MILL</b>			11. BIRTHPLACE (State or foreign country) <b>DWASSO, MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>RUBEN HARVEY</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			14. NAME OF HUSBAND OR WIFE <b>ANNA 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>492-09-9154A</b>		17. INFORMANT'S SIGNATURE OR NAME <b>ANNA HARVEY</b>			ADDRESS <b>3516 N. 9TH. ST.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>uremia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 Wks</b>	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Hypertrophy of Prostate</b>							
		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>610X</b>					
22. I hereby certify that I attended the deceased from <b>10/4</b> , 19 <b>50</b> , to <b>10/11</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>10/10</b> , 19 <b>50</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>H. Livingston</b>				23b. ADDRESS <b>1515 Lafayette Av.</b>		23c. DATE SIGNED <b>10/12/50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>10-14-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEM.</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, CO. MO</b>			
DATE REC'D BY LOCAL REG. <b>OCT 13 1950</b>		REGISTRAR'S SIGNATURE <b>B. Lancaster</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>SUEDMEYER + SONS</b>				ADDRESS <b>3934 N. 20 ST.</b>

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

*None*

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed *Walter J. Schmitt*

Signed.....  
Student Embalmer

Licensed Embalmer No. *3696*

P. O. Address *3734 N 20 St*

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 this body is not embalmed, fact should be so stated above.