47782 a

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

## MISSOURI STATE BOARD OF HEALTH
### BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Ozark
Township Big Creek
or
Village
or
City (NO St. Ward)

Registration District No. 920
Primary Registration District No. 5858
File No. 47782 A
Registered No. 31

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James K. Hart

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | Widower |

6 DATE OF BIRTH: March 4, 1845 (Month) (Day) (Year)

7 AGE: 73 yrs. 9 mos. 4 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Whitley County Ky.

PARENTS

10 NAME OF FATHER: Col. Peter Hart

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florida Gibson
(Address) Duggansville Mo.

15 Filed March 3, 1919 Mary F. Johnson Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. 12/5 (Month) (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 12/2, 1918, to 12/5, 1918, that I last saw h. im alive on 12 Mission Mo, 1918, and that death occurred, on the date stated above, at 1:50 a. m.

The CAUSE OF DEATH* was as follows:
Paralysis
82 1/
(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Florida Gibson (Nurse.) M. D.
3/3, 1919 (Address) Duggansville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death 1 yrs. ..... mos. ..... ds. In the State 17 yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence 54

19 PLACE OF BURIAL OR REMOVAL: Duggansville Mo
DATE OF BURIAL: 12/6, 1918

20 UNDERTAKER: J. Sterling Hart
ADDRESS: Duggansville Mo

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

## MISSOURI STATE BOARD OF HEALTH
### BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
*or*
Village ..... Primary Registration District No. ..... Registered No. .....
*or*
City ..... (NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed .....

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191..... |
|---|---|
| 20 UNDERTAKER | ADDRESS |