

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

Do not use this space.

**1. PLACE OF DEATH**

County Ralls  
Township Clay  
City Reynolds (No. ....)

Registration District No. 728  
Primary Registration District No. 594

File No. 2201  
Registered No. 271  
St. .... Ward)

**2. FULL NAME** Anna Roselle Hardy

(a) Residence No. Ralls Co. Mo. St. .... Ward. ....  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan, 6, 27. 19

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Francis R Hardy

17. I HEREBY CERTIFY, That I attended deceased from .....  
er ..... 19....., to ..... 19.....  
that I last saw h. .... alive on ..... 19....., and that  
death occurred, on the date stated above, at 10:25 A.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 6, 1852

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
74 4 20

Pneumonia  
107A  
57A  
CONTRIBUTORY (SECONDARY) Arthritis (duration) 2 yrs. mos. ds.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....  
8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
WAS THERE AN AUTOPSY?.....  
WHAT TEST CONFIRMED DIAGNOSIS.....

9. BIRTHPLACE (CITY OR TOWN) Albany  
(STATE OR COUNTRY) New York

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont know  
(STATE OR COUNTRY) .....

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Maine  
(STATE OR COUNTRY) .....

(Signed) A. R. Roselle, M. D.  
Jan 8, 1927 (Address) 524 - Broadway  
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT Mrs. F. L. Clarkins  
(Address) Reynolds Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Riverside DATE OF BURIAL 1/9, 27 19

15. FILED 1/20-27 J. H. Bond  
REGISTRAR

20. UNDERTAKER Wm. M. Smith's Embal  
ADDRESS

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

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Rolla  
Township Clay  
City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 728  
Primary Registration District No. 5961

File No. \_\_\_\_\_  
Registered No. 221

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

14. INFORMANT (Address) \_\_\_\_\_

15. FILED 4-19-27 JH Ward REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan, 6, 1927

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, (that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

pneumonia  
broncho  
arthritis  
CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D. \_\_\_\_\_, 19\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

N. B. Attention should be given to the instructions on the reverse side of this certificate. The information should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRAR - NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE A

SUPPLEMENTARY

5-2201