

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

Do not use this space.

1045

**1. PLACE OF DEATH**

County Gentry Registration District No. 310 File No. ✓  
 Township \_\_\_\_\_ Primary Registration District No. 5429-9 Registered No. 50  
 City Darlington (No. 4126) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Keturah Belle Hardy

(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 female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 22-1862

7. AGE YEARS MONTHS DAY If LESS than 1 day, hrs. or min.  
66 7 9

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
 (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) Ind.

**10. NAME OF FATHER**

Joseph Mendenhall

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Ohio

**12. MAIDEN NAME OF MOTHER**

Francis Shaffer

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Tenn.

**14.**

INFORMANT Mrs. Lillie Gools  
 (Address) Darlington Mo

**15.**

FILED 1-3-29 Mary Deland  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1-1929

17. I HEREBY CERTIFY That I attended deceased from 12-21-1928, to 1-1-1929 that I last saw her alive on 12-31-1928, and that death occurred, on the date stated above, at 2.9 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Influenza  
131 Pneumonia  
115 Nephritis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 da.  
 CONTRIBUTORY (SECONDARY) Nephritis  
 (duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? ✓

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) Braun H. Rose, M. D.

(Address) 1-2-, 1929 Albany, Mo.

\*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.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Winslow **DATE OF BURIAL** Jan 3 1929

**20. UNDERTAKER** A. T. Bare ADDRESS Albany

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.

JAN 23 1929  
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state should be... PHYSICIAN'S should state  
OCCUPATION is very important  
Exact state...

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supplied

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should be

**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 Lentz  
Township Darlington  
City Darlington

Registration District No. 310  
Primary Registration District No. H 186

File No. ....  
Registered No. 50  
St. .... Ward)

**2. FULL NAME**

Katharine Belle Hardy

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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 ..... 19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 - 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Influenza  
with Pneumonia  
(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) Nephritis  
(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

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.

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

20. UNDERTAKER ADDRESS

NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
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SUPPLEMENTARY

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