

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

Do not use this space.

15259

1. PLACE OF DEATH

County Jasper
Township Lincoln
City..... (No..... Ward)

Registration District No. 410
Primary Registration District No. 5568

File No.....
Registered No. 9

2. FULL NAME Orin Hart

(a) Residence. No..... St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 60 yrs. ✓ mos. ✓ ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Ma O. Hart

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 4 1845

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
83 10 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(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) Ohio

10. NAME OF FATHER Hiram Hart

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) New York

12. MAIDEN NAME OF MOTHER Rebecca Cadwallader

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

14. INFORMANT Mrs. Orin Hart
(Address) Jasper Mo

15. FILED Apr 9 1929 D A Holmes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 7 - 1929

17. I HEREBY CERTIFY That I attended deceased from April 5 - 1929 to April 7 - 1929 that I last saw her alive on April 7 - 1929, and that death occurred, on the date stated above, at 9 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

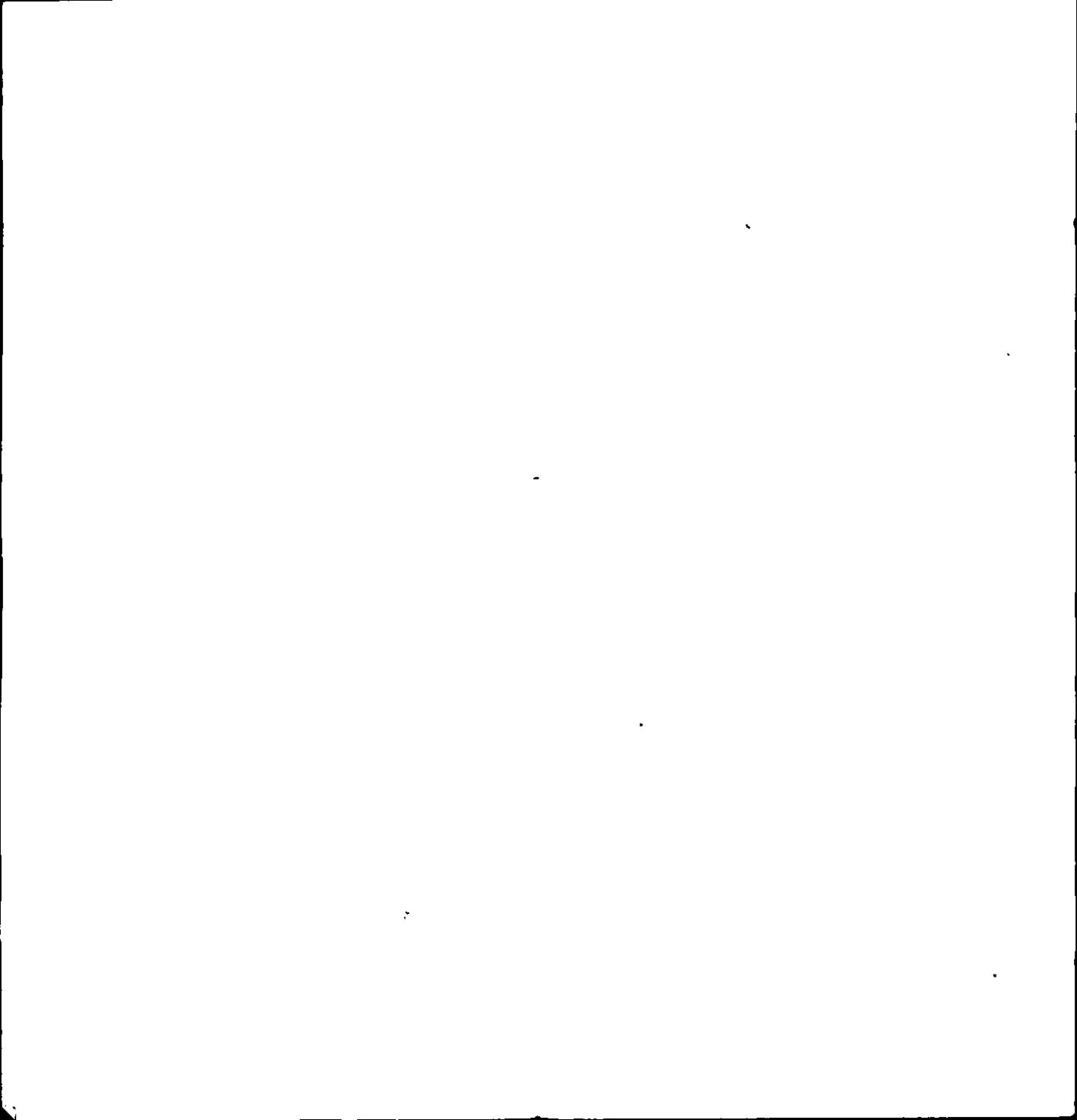
Influenza
II R
..... (duration) yrs. mos. 4 ds.
CONTRIBUTORY Flu Pneumonia
(SECONDARY)
..... (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed)..... M. H. Knott M. D.

(Address) Jasper, 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 Magoffin Cem DATE OF BURIAL 1929

20. UNDERTAKER Tetter Bros ADDRESS Jasper Mo



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jasper Registration District No. 410 File No. _____
 Township Johnson Primary Registration District No. 3-5-6-8 Registered No. 9
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Quin Hart

(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 M 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 9/29/29 W. A. Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 7 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:

_____ (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) _____ (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 Magoffin Care DATE OF BURIAL 4-11-29

20. UNDERTAKER Peter Bros ADDRESS Magoffin mo

SUPPLEMENTARY

65-15059