

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

Do not use this space.

28099

1. PLACE OF DEATH

County Jasper Registration District No. 411
Township Jasper Primary Registration District No. 2003
City Jasper (No. St. John's Hospital) Registered No. 294
St. _____ Ward _____

2. FULL NAME

Neva Maud Hardwick
(a) Residence. No. 1921 Margaret St. _____ Ward. John's Hospital
(Usual place of abode) Greene (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 MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8 - 1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
56 10 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) Good
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

10. NAME OF FATHER James Fowler

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ill

12. MAIDEN NAME OF MOTHER Ellen Hedge

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

14. INFORMANT Paul Hardwick (Address) Greene

15. FILED 8-12-29 W. R. ... REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 1929

17. I HEREBY CERTIFY That I attended deceased from July 20, 1929, to Aug 11, 1929, that he last saw him alive on Aug 10, 1929, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Embolic

CONTRIBUTORY (SECONDARY) Gun shot wound
lung (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF July 20, 1929

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____

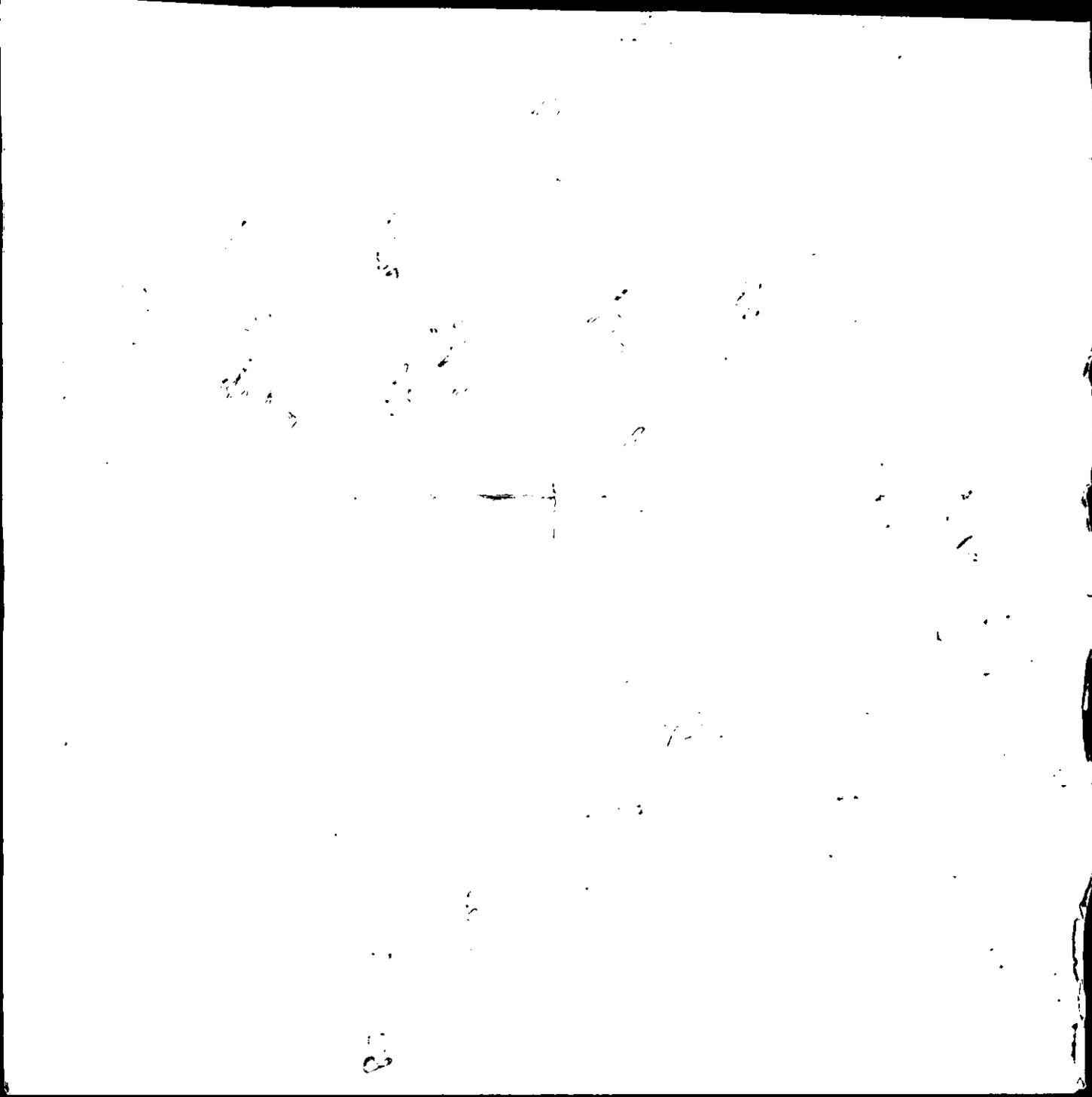
(Signed) H. C. ..., M. D.

(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 Mt Hope DATE OF BURIAL Aug 13 1929

20. UNDERTAKER P. M. Clark ADDRESS Greene



**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 Wasper

Registration District No. 711

File No.

Township

Primary Registration District No. 2002

Registered No. 334

City Waples

(No.)

St. Ward)

2. FULL NAME

Neva Maud Hardwick

(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)

wid

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)

PARENTS

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

10/5/29 Wason Black REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 29

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:

Embolism
Homocide

CONTRIBUTORY (SECONDARY) gun shot wound (duration) yrs. mos. ds.

in lung (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

19

20. UNDERTAKER

ADDRESS

FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

