

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

Do not use this space.

38461

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

1003

Township.....

Primary Registration District No.....

City St. Louis

(No. 418)

S. Garrison

File No.....

Registered No. 10848

St. \_\_\_\_\_ Ward)

**2. FULL NAME** Sarah Hardy

(a) Residence. No. 418 S. Garrison Ave. St. 18 Ward.

(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 <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not Known

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, .....hrs. or .....min.
<u>Abt. 57</u>				

**8. OCCUPATION OF DECEASED**

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

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

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) W. Va.

PARENTS

10. NAME OF FATHER James Alexander

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

12. MAIDEN NAME OF MOTHER Hattie Smith

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

14. INFORMANT Miss Sedalia Hardy  
(Address) 418 S. Garrison Ave.

15. FILED NOV 5 1929 Cap C. Hardy REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY that I attended deceased from 8:15 Nov 1 1929 that I last saw him alive on Nov 1 1929 and that death occurred, on the date stated above, at 2:40 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Interstitial Nephritis  
chronic  
131 (duration) 3 yrs. mos. ds.  
CONTRIBUTORY  
(SECONDARY) Mitral Insuffic  
ency (duration) 1 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? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. J. [Signature] M. D.

Address) 115 [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**

Greenwood Cem.

Nov. 7, 19 29

**20. UNDERTAKER**

J. H. Harrison

**ADDRESS**

2906 Lawton

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.

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