

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

Do not use this space.

11263

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis, mo.* (No. *City Hospital #2*)

Registration District No. **791**
1003
Primary Registration District No.

File No.
Registered No. **3373**
St. Ward)

2. FULL NAME

Sallie Hardy
(a) Residence. No. *4200 S. Madison St.* *15* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>col.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>married</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *William Hardy*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *12-16-1893*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<i>36</i>	<i>3</i>	<i>15</i>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *House-work*
(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) *mo.*

PARENTS

10. NAME OF FATHER *John Pope*

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) *mo.*

12. MAIDEN NAME OF MOTHER *Abbie Hurman*

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

14. INFORMANT *A. Gertrude Creath*
(Address) *City Hospital #2*

15. FILED *4 1933* *Miss C. Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-31-1930*

17. I HEREBY CERTIFY, That I attended deceased from *3-30-1930* to *3-31-1930* that I last saw her alive on *3-31-1930* and that death occurred, on the date stated above, at *8:45 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
930
(duration) - yrs. *5* mos. *8* ds.

CONTRIBUTORY (SECONDARY) *9015*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *No.* DATE OF.....

20. WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical*
(Signed) *A. E. Hale*, M. D.
4/1/30 (Address) *City Hosp. #2*

*State the DISEASE CAUSING DEATH, or if 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 *Washington Park Home* DATE OF BURIAL *April 19 30*

20. UNDERTAKER *Peoples Fund Co.* ADDRESS *Franklin*

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.

