

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

Do not use this space.

2413

1. PLACE OF DEATH

County *Keosauqua*
Township *Arlyton*
City *Keosauqua*

Registration District No. *676*
Primary Registration District No. *5899*

File No. _____
Registered No. *2*
St. _____ Ward) _____

2. FULL NAME

(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.

Thomas Edward Hargis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* | 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 *Mabel Hargis.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *4-9-1886*

7. AGE YEARS *44* MONTHS *8* DAYS *37*
If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *laborer*
(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) *Ill.*

10. NAME OF FATHER *William Hargis*

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

12. MAIDEN NAME OF MOTHER *Mary Large*

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

14. INFORMANT *Sarah Allen*
(Address) *Jerome*

15. FILED *1/20*, 19. *31*. *B.T. Austin*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 6* 19 *31*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 4*, 19*31*, to *Jan 6*, 19*31*, that I last saw him alive on *Jan 6*, 19*31*, and that death occurred, on the date stated above, at *6:30 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
mitral regurgitation

CONTRIBUTORY (SECONDARY) *9200*
(duration) _____ yrs. _____ mos. _____ 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) *Widney McFarland*, M. D.
1/4, 19 *31* (Address) *Pella 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 *Pella mo* DATE OF BURIAL *Jan 8 1930*

20. UNDERTAKER *Fred W. Gilbert* ADDRESS *Dixon, mo*

K. E.—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.

WHITE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FEB 20 1931

