

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

Do not use this space.

✓ 32339

1. PLACE OF DEATH  
 City St. Louis Registration District No. 985-  
 Township Parkwood Primary Registration District No. 3037  
 No. 477 So. Clay Ave St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME Catherine Spallcross Hard  
 (a) Residence. No. 477 So. Clay Ave St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 23 yrs. - mos. - da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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 Miron Hard  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 15 1844  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
87 | 7 | 10  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work At Home  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/25 1931  
 17. I HEREBY CERTIFY, That I attended deceased from 9/5, 1931, to 9/24, 1931, that I last saw him alive on 9/25, 1931, and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

R. Lobes pneumonia  
186A  
174B  
108 " (duration) yrs. mos. 10 da.  
 CONTRIBUTORY Gracile R. clavicle  
 (SECONDARY) (duration) yrs. mos. da.

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? Physiologic examination  
 (Signed) W. H. Leslie, M. D.  
9/25 1931 (Address) Kirkwood, 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.

9. BIRTHPLACE (CITY OR TOWN) Gallipolis  
 (STATE OR COUNTRY) Ohio  
 10. NAME OF FATHER Joseph Spallcross  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Philadelphia  
 (STATE OR COUNTRY) Penn.  
 12. MAIDEN NAME OF MOTHER Emily Henderson  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Henderson  
 (STATE OR COUNTRY) West Virginia

14. INFORMANT Thomas E. Itard  
 (Address) 477 S. Clay, Kirkwood  
 15. FILED 9/30 31 G. E. Barrett  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION OR REMOVAL Gallipolis Ohio DATE OF BURIAL Sept 21 1931  
 20. UNDERTAKER Parker and Co. Webster Groves  
 ADDRESS \_\_\_\_\_



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis  
Township Richwood  
City Richwood (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 985-  
Primary Registration District No. 3037

File No. \_\_\_\_\_  
Registered No. 203

**2. FULL NAME**

Catherine Shallcross Ward

(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 ♀ 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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19\_\_

19. UNDERTAKER (ADDRESS)

20. FILED 11/10 1931 C. E. Burt Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/25-1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

P. Tuberc. Pneumonia Date of onset \_\_\_\_\_

Other contributory causes of importance:

Fracture P. clavicle from fall from bed. A. H. Adams

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, & homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_

(Signed) C. E. Burt, M. D.  
(Address) Richwood, Mo.

SUPPLEMENTARY

FEE SHALL NOT RECEIVE A FEE FOR CERTIFICATE

S-3233T