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

File No. 3753
Registered No.

1. PLACE OF DEATH
County Buchanan — Registration District No. 84
Township — Primary Registration District No. 4052
City Rushville Mo (No. ..., ... St. ..... Ward)

2. FULL NAME John Daniel Hargrove
(a) Residence (Usual place of abode) No. Rushville Mo RR3 Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

11
4
1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W.	Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Martha Jane Hargrove

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 1864

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
67	3	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer 1
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Near Rushville Mo 1
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Harrison B. Hargrove
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky. 2
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER ~~[illegible]~~ Caroline Sewell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kan
(STATE OR COUNTRY)

14. INFORMANT Reuben Hargrove.
(Address) RR3 - Rushville Mo.

15. FILED 2-5-1932 L. N. Ginger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 5 1932

17. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1932, to Feb 6, 1932 that I last saw him alive on Feb 5, 1932, and that death occurred, on the date stated above, at 5 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular heart disease
92A 92A (duration) 1 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED (1)
IF NOT AT PLACE OF DEATH —
(1) DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? usual test
(Signed) Dr E B McAdow, M. D.
2/5, 1932 (Address) DeKalb 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~~ Sugar Creek County — DATE OF BURIAL 2/7 1932

20. UNDERTAKER Sawin & Douglass — ADDRESS Atchison Kan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

APR 25 1932

This was held by Doctor

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...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.

PERSONAL AND STATISTICAL PARTICULARS

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

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.....

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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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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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:

.....
.....
.....
..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
..... (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

S. NO. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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