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.

SEP 30 1934

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

Do not use this space.

29430

File No. 28

Registered No.

1. PLACE OF DEATH

County: Jackson

Township: Kansas

City: (No. 225 No Kensington Ave Ward)

Registration District No. 389

Primary Registration District No. 1000

2. FULL NAME: Mrs Harriett Hallard

(a) Residence, No. 1225 No Kensington Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

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: John R Hallard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sept 17-1864

7. AGE: YEARS 69 MONTHS 10 DAYS 27 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: housewife

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): Monroe County Ohio

FATHER

13. NAME: Crawford Crouse

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

MOTHER

15. MAIDEN NAME: Unknown

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

17. INFORMANT (ADDRESS): Mrs Charles T. Leonard 225 No Kensington

18. BURIAL, CREMATION, OR REMOVAL

PLACE: Mt. Moriah DATE: August 17, 1934

19. UNDERTAKER (ADDRESS): Swanwecomer & Sons

20. FILED: 8/16, 1934 M. M. Tasman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug 14, 1934

22. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1934, to Aug 14, 1934

I last saw her alive on Aug 14, 1934. Death is said to have occurred on the date stated above, at 7 30 a.m.

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

	Date of onset
Toxemia from extensive cellulitis	8/11/34
Other contributory causes of importance: Acute Tonsillitis	8/9/34

Name of operation: no. Date of:

What test confirmed diagnosis? autopsy. Was there an autopsy? yes

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

Accident, suicide, or 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? no

If so, specify

(Signed) Dean S Rising, M. D.

(Address) 607 Argyle Bldg

#2

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.
3847

Kansas City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Harriett Evelyn Holland

Who died at _____ on Aug 14 - 1934

Residence: No. _____ St. _____

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex F Color or race W ~~Single~~, married, ~~widowed or divorced~~: _____

Date of birth _____ Age: Years 69 Months 10 Days 27

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Taxemia from Extensive Cellulitis

~~Date deceased last worked at this occupation: Month _____ Year _____~~

~~Birthplace (State or country) _____~~

~~Birthplace of father (State or country) _____~~

~~Birthplace of mother (State or country)~~ ac Tonsilitis

Principal cause of death: Acute Tonsillitis from Hemolytic Streptococcus

115 a 2

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? yes

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

Accident, suicide, or 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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician DR. D. S. RISING

Address of physician 602 ARGYLE BLDG

Signature of Registrar M. M. Crowe Date filed 8/16/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh M.D.

Special Agent.

Reg. Dist. No.

Primary Reg. Dist. No.

S-29430