

30 AUG 16 1939

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

25593  
Do not use this space.

1. PLACE OF DEATH

(a) County Gentry Registration District No. 309  
(b) Township Howard Primary Registration District No. 5434  
(c) City or \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 32

2. PRINT FULL NAME Charles Hart

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 24, 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
64 6 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. farmer  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

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

FATHER 13. NAME William Hart

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

MOTHER 15. MAIDEN NAME Elisha Nicholson

16. BIRTHPLACE (CITY OR TOWN) Adkins Co.  
(STATE OR COUNTRY) N.C.

17. INFORMANT Mrs. Rose Keasling  
(ADDRESS) Albany, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE New Friendship DATE August 1, 1939

19. FUNERAL DIRECTOR (NAME) Brooks Funeral Home  
(ADDRESS) Albany, Mo.

20. FILED July 31, 1939 W. T. Martin  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-25-1939, to 7-30-1939

I last saw h. in alive on 7-30-1939. Death is said to have occurred on the date stated above, at 2:10 PM.  
The principal cause of death and related causes of importance were as follows:

Ch. Nephritis  
arterial Hypertension  
Ch. Myocarditis  
Date of onset 1927?

Other contributory causes of importance:  
hemiplegia - (2 proeme Dec '38)  
due to cerebral hemorrhage

Name of operation G Date of \_\_\_\_\_  
What test confirmed diagnosis? skin Was there an autopsy? no

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) Frank H. Rose, M. D.  
(Address) Albany, Mo.

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.

RECEIVED

District No. 11;

District File Number 839-1010

Date Filed AUG 9 1939

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*Clifford Banks*

..... Licensed Embalmer No. 3329

..... P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.