

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

35544
 Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township St. Joseph Primary Registration District No. 1001
 (c) City St. Joseph (d) Street No. 3122 S. 15th St.
 (e) Length of residence in city or town where death occurred 35 yrs. 9 mos. 28 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Eva Hardinger
 (a) Residence, No. 3122 S. 15th 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 Female 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) December 19, 1903

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 9 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
 9. Industry or business in which work was done, as 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) St. Joseph
 (STATE OR COUNTRY) Missouri

FATHER 13. NAME Joseph Hardinger

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

MOTHER 15. MAIDEN NAME Theresa

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

17. INFORMANT Mary Hardinger
 (ADDRESS) 3122 S. 15th Str. St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cent.
 PLACE St. Joseph, Mo. DATE Oct. 18, 1939

19. FUNERAL DIRECTOR (NAME) H. O. Sidenfaden & Son
 (ADDRESS) 1802 Union Str. St. Joseph, Mo.

20. FILED Oct 18 1939 H. J. Nettlesh
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 17, 1939, to Oct 17, 1939

I last saw her alive on Oct 16, 1939. Death is said to have occurred on the date stated above, at 9:20 P.M.

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

Intrathoracic gaster

Date of onset 8 yrs ago

Other contributory causes of importance:
Pelvic abscess

Name of operation drained pelvic abscess Date of July 28-39
 What test confirmed diagnosis laboratory Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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) S. E. McElaney, M. D.
 (Address) 491 Ballinger Bldg
St. Joseph, Mo.

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

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MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Robert R. Harrington
Licensed Embalmer No. 3258
P. O. Address St. Joseph, Mo.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

35-544
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township St. Joseph Primary Registration District No. 1001
 (c) City St. Joseph (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.

2. PRINT FULL NAME Eva Hardinger
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (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.
	<u>35</u>	<u>9</u>	<u>28</u>	

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. _____
 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) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED 10/18 1939 S. E. Melaney Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 17 1939

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:
Intoxication
 Date of onset 12/11/38

Other contributory causes of importance:
Alcohol abuse
Do not know name
 Name of operation drainage Date of _____
 What test confirmed diagnosis Clinical (with or without 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? _____
 If no, specify _____
 (Signed) S. E. Melaney, M. D.
 (Address) St. Joseph Mo

SUPPLEMENTARY

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.

6. CERTIFICATE SHALL NOT BE GIVEN UNTIL ALL INFORMATION HAS BEEN OBTAINED AND ALL NECESSARY TESTS COMPLETED.

