

FILED FEB 24 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1492

Registration District No. 7

Primary Registration District No. 3001

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Green-Smith Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Two Weeks
(Specify whether years, months or days)
 In this community Four years

3. (a) PRINT FULL NAME John Baptist Hardy

3. (b) If veteran, name war World war 3. (c) Social Security No. 490-10-7540

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Pearl Winget 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased Jan 21, 1890
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>50</u>	<u>0</u>	<u>22</u>	hr. <u>0</u> min. <u>0</u>

9. Birthplace Novelty Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Hdwe. & Implements

11. Industry or business Machinery

12. Name William Fredrick Hardy

13. Birthplace Adams County Ill
(City, town, or county) (State or foreign country)

14. Maiden name Anna Kumbaugh

15. Birthplace Germantown Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Hardy

(b) Address 915 S. Fifth St.

17. (a) Burial (b) Date thereof Feb. 15, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park Cemt. Davis Funeral Home

18. (a) Signature of funeral director Spencer L. Freeman
 (b) Address Kirksville, Mo.

19. (a) 2-17-40 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
 (c) City or town Kirksville
(If outside city or town limits, write "RURAL")
 (d) Street No. 915 S. Fifth St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12th
 year 1940 hour 8 minute 10 A.M.

21. I hereby certify that I attended the deceased from Jan 29
1940, to Feb. 12, 1940
 that I last saw him alive on Feb. 12, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration
2 days

Due to Septic Emboli from thrombi on aortic valve 3:00

Due to Pneumonia & small empyema Jan 22

Other conditions Overcome Carbon monoxide for five minutes Jan 19
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy Pneumococcus meningitidis - aortic valve thrombus - Pneumonia & empyema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature George E. Gam (M. D. or other) MD

Address Kirksville, Mo Date signed 2-17-40

JUL 3 1945

RECEIVED

District Health Officer No. 10

District File Number 2-40-455

Date Filed Feb. 21 1940

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 *Harold T. Nagal*

Licensed Embalmer No. 4076

P. O. Address *Triskville, Va.*

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.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14927

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirkville
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME John B. Hardy
(b) If veteran, name war (c) Social Security No.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced
6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50

9. Birthplace (City, town, or county) or foreign country

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years

20. DATE OF DEATH Month Feb. day 12 - 40
year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19
that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis
Septic emboli from valve
thrombosis on Prostic
Due to meningitis + emphysema
Overcome Carbon
Due to meningitis 6 hrs for 5 min
while working in garage
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accidental
Carbon monoxide poisoning - Death from secondary
(b) Date of occurrence unaffected
(c) Where did injury occur? Kirkville Adair Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Ma Farmers Assoc Garage
(Specify type of place)
While at work? Yes (e) Means of injury CO poisoning

23. Signature George E. Grinn (M. D. or other) MD
Address Kirkville, Mo Date signed 3-15-41

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

