

Registration District No. 336Primary Registration District No. 4199

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Harrison  
 (b) City or town Cainsville  
 (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 2  
 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 years, months or days

3. (a) PRINT FULL NAME William S. Hart (30)

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 300-09-6885

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

6. (b) Name of husband or wife Fella Hart 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Feb 9 1867  
 (Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mercur County Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation W. P. A.

11. Industry or business \_\_\_\_\_

12. Name J. E. Hart

13. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

14. Maiden name Lachage  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Fella Hart

(b) Address Cainsville Mo

17. (a) Burial (b) Date thereof July 7 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director Noel Mass

(b) Address Princeton Mo

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

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Harrison

(c) City or town Cainsville  
 (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.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 6  
 year 1940 hour 4.30 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 20-40  
 \_\_\_\_\_, 19\_\_\_\_ to June 26, 1940

that I last saw him alive on June 26  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to Organic Disease of Heart

Due to Mitral Insufficiency of the Heart

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy no

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?  
304

While at work? no (Specify type of place) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

23. Signature H. Nalley (M. D. or other) \_\_\_\_\_

Address Cainsville Mo Date signed \_\_\_\_\_

RECEIVED

District Health Officer No. 11,

District File Number

440-1329

Date Filed

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

Neil Gross

Licensed Embalmer No. 2634

P. O. Address Princeton, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28610

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 336

Primary Registration District No. 4199

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
KOWENA

1. PLACE OF DEATH:

(a) County Harrison  
(b) City or town Caineville  
(If outside city or town limits, write "RURAL" and name of township)  
(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 (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME

Wm S. Hart

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

m

5. Color or race

w

6. (a) Single, widowed, married, divorced

m

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

73

4

27

hr min.

9. Birthplace

(City, town, or county)

(State 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

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

July 9

(b)

C E Oden

(Interreceive 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.

DECLARATION OF DEATH CERTIFICATION

20. DATE OF DEATH: Month 7 day 6  
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

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)

(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 (M. D. or other)

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

