

OCT 18 1940

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

Do not use this space.

32516

1. PLACE OF DEATH

County Maries

Registration District No. 5-1-1

File No.

Township Jefferson

Primary Registration District No. 5-1-1

Registered No.

City

(No.)

St.

Ward)

2. FULL NAME

Mary J. Hart

(a) Residence, No. Maries Co., Mo.

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

John E. Hart

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

Dec. 4, 1867.

7. AGE

YEARS

72

MONTHS

9

DAYS

0

IF LESS than 1 day,

hrs. min.

OCCUPATION

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

housekeeper in home.

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)

Mo.

FATHER

13. NAME William Stone

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

Indiana

MOTHER

15. MAIDEN NAME Rebecca Wiseman

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

Mo.

17. INFORMANT (ADDRESS)

Chas. E. Stone R. #1, Bland, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE High Gate

DATE Sept 4, 1940

19. UNDERTAKER (ADDRESS)

S. G. Licklider Belle, Mo.

20. FILED

Oct 15 1940 Mrs. Lenora Johnson Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 4, 1940

22. I HEREBY CERTIFY, That attended deceased from Aug 10, 1940 to Sept 4, 1940

I last saw her alive on Sept 12, 1940. 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:

Chronic Gastritis Date of onset 11/2

Other contributory causes of importance:

Anemia (Pseudo)

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

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

Accident, suicide, or homicide?

Date of injury

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) J. B. Underwood

M. D.

(Address) High Gate 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

WRITE PLAINLY, WITH UNFADING INK

1152

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **325-16**

Registration District No. **341**

Primary Registration District No. **6730**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Jefferson**
(b) City or town **Jefferson**
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Mary J Hart

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W**

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

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 **72** Months **9** Days _____ If less than one day _____ 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 (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 **Sept** day **4**
year _____ 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: **Chronic Gastritis**

Due to **Causes 26 1/2**

Due to **71 1/2**

Other conditions (Include pregnancy within 3 months of death) **Anemia (severe)**

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) Means of injury _____

23. Signature **J.B. Underwood** (M.D. or other)
Address **High Gate** _____

SUPPLEMENTAL CERTIFICATE

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

