

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3014

State File No. _____

Registration District No. 262

Primary Registration District No. 5897

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Clark
(b) City or town Rural Bayon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(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 Mary Hadden

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race 1 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 5 1861
(Month) (Day) (Year)

8. AGE: 81 Years 1 Months 11 Days If less than one day hr. _____ min. _____

9. Birthplace Dade Co. Mo
(City, town, or country) (State or foreign country)

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER { 12. Name Benjamin Miller
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature P. A. Clark

(b) Address Elijah Mo

17. (a) Burial (b) Date thereof Dec 3 '42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baptist Church Friends

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-1-1942 (b) P. A. Beach
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Clark
(c) City or town Elijah Mo
(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. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1
year 1942 hour 10 minute a M.

21. I hereby certify that I attended the deceased from Dec 1 until Dec 1 that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension
Due to _____

Other conditions (Include pregnancy within 3 months of death) 83a

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 P. A. Beach (M. D. or other) Coroner

Address Elijah Mo Date signed 12-1-42

RECEIVED
District Health Officer No. 6,
District File Number 143-71
Date Filed JAN 20 1943

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.....

Licensed Embalmer No.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3014

Registration District No. 262

Primary Registration District No. 5887

Registrar's No.

1. PLACE OF DEATH:

- (a) County Ozark
(b) City or town Rural
(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 Mary Harder

3. (b) If veteran, name war 3. (c) Social Security No.

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

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

7. Birth date of deceased Oct 5 (Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 12 If less than one day min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) (Date received local registrar) (b) CA Beach (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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Year 1942 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 10 1942 that I last saw him alive on 10 1942 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

Duration

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

- Address Date signed

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

SUPPLEMENTARY

[The page contains extremely faint, illegible text, likely a scan of a document with very low contrast or a blank page with noise.]