S. No. 2
M—5-42
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23950

AUG 6 1943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3203

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

1. PLACE OF DEATH:

(a) County Jackson County

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Children's Mercy Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Hours (Specify whether
In this community 2 Hours
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48 3

(c) City or town Kansas City, Mo. 8
(If outside city or town limits, write "RURAL")

(d) Street No. 1012 Bellefountaine
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Peggy Rose McHardie

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased August (Month) 30 (Day) 1942 (Year)

8. AGE: Years | Months 10 | Days 8 | If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business —

FATHER
12. Name Andrew McHardie
13. Birthplace (City, town, or county) Kansas (State or foreign country)

MOTHER
14. Maiden name Marjorie Fenan
15. Birthplace (City, town, or county) Kansas (State or foreign country)

16. (a) Informant Marjorie McHardie
(b) Address 1012 Bellefontaine

17. (a) ~~Burial~~ Removal (Burial, cremation, or removal) (b) Date thereof July 23, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Highland Park Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.
(b) Address Kansas City, Mo.

19. (a) 7-22-43 (Date received local registrar) (b) P. E. Brown Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22nd
year 1943 hour 12:30 AM minute M.

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

Immediate cause of death Post Mortem
Bronchopneumonia

Due to Dilatation of right heart
Bilateral otitis media

Due to Hyperemia of brain

Other conditions Passive congestion of viscera
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 107

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)
(d) 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 John H. Gaskins M.D. (M.D. or other)
Address Kansas Children's Hospital Date signed 7-23-43

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.

S. No. 2B
M—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 3203

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town KC (If outside city or town limits write "RURAL")

(d) Street No. 1012 Bellefontaine (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Peggy Rose McHardie

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

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 hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22 year 1943 hour minute M.

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

Immediate cause of death: Post Mortem

Due to: 1- Broncho pneumonia
2- Dilatation of right heart
Due to: 3- Bilateral Otites media
4- Hyperemia of brain

Other conditions (Include pregnancy within 3 months of death): Passive Congestion of viscera

Major findings: Of operations: Bronchopneumonia actual

Of autopsy: cause of death,

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) 107

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature John H Harkins M.D. (M. D. or other)

Address Date signed

S-23950