

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25052**
Registrar's No. **153**

Registration District No. **137**

Primary Registration District No. **3023**

1. PLACE OF DEATH:

(a) County **Henry**
(b) City or town **CLINTON**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Community Clinic Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether
In this community
years, months or days)

3. (a) PRINT
FULL NAME

Mattie J. Harding

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 MARRIED

6. (b) Name of husband or wife

Clarence Harding

6. (c) Age of husband or wife if

alive years

7. Birth date of deceased

18 30 1889
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

53

6

16

hr. min.

9. Birthplace

Carleton Mo
(City, town, or county) (State or foreign country)

Mo
(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

O P Pound

13. Birthplace

UNKNOWN 9
(City, town, or county) (State or foreign country)

14. Maiden name

unknown

15. Birthplace

unknown
(City, town, or county) (State or foreign country)

16. (a) Informant

Clarence Harding

(b) Address

CLINTON Mo

17. (a)

B4191
(Burial, cremation, or removal)

(b) Date thereof

7 28 43
(Month) (Day) (Year)

(c) Place: burial or cremation

Highland Cem

18. (a) Signature of funeral director

Edna Williamson

(b) Address

Clinton Mo

19. (a)

July 27, 1943
(Date received local registrar)

Georgia Kitcher
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Henry**
(c) City or town **Clinton**
(If outside city or town limits, write "RURAL")
Street No. **10 Mi E of Clinton**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **26**
year **1943** hour minute **5:00 P.M.**

21. I hereby certify that I attended the deceased from **July 21**
1943 to **July 26**, 1943

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

Immediate cause of death

Coronary atherosclerosis 4 days

Due to **coronary atherosclerosis** 3 weeks

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 **Ray J. Jordan** (M. D. or other)

Address **Clinton Mo** Date signed **7/27/43**

RECEIVED

District Health Officer No. 7,

District File Number

Date Filed

7-43-788
8-6-43

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

Fred Wilkinson

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

AUG 10 1940

State File No.

Registration District No. 187

Primary Registration District No. 3023

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(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

Mathew J. Harding

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex M Color or race W
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 Dec 30 (Month) (Day) (Year)

8. AGE: Years 53 Months 6 Days 10 If less than one day min.

9. Birthplace (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) (Data received local registrar) (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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
that I last saw him alive on
and that death occurred on the date and hour stated above
Immediate cause of death Pneumonia (Hypertension)
Direct cause of death

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 (Ray J. Goodman) (M. D. or other)
Address W. W. W. or Mo. Date signed

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

S-25052