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-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED DEC 28 1943

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 272

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City, Mo

(c) Name of hospital or institution: 514 Missouri  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

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

(d) Street No. 1514 - Monroe (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME WILLIAM HOARD

3. (b) If veteran name war CIVIL WAR 3. (c) Social Security No. [REDACTED]

4. Sex MALE 5. Color or race Negro 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years 99 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business Callaway Farmer

12. Name Callaway Farmer

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

14. Maiden name Harnett Hoard

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

16. (a) Informant James Hoard

(b) Address 514 Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-43  
(Month) (Day) (Year)

(c) Place: burial or cremation National Cem.

18. (a) Signature of funeral director James Hoard

(b) Address 703 Jefferson St. Home

19. (a) 12-19-43 (Date received local registrar) (b) Harris Richter (Registrator's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11th year 1943 hour 2 minute 50 AM

21. I hereby certify that I attended the deceased from Dec. 1 1943 to Dec. 11 1943 that I last saw him alive on Dec. 11 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic post-infectious interstitial nephritis

Due to Arteriosclerosis + old age

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 131a

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) (c) Means of injury \_\_\_\_\_

23. Signature R. S. Richardson (M.D. or other) Address Jefferson City Date signed 12/14/43

Duration many years

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER  
WRITING PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
-21-43  
NEB

1-67-2  
1-6-1-1-1  
X I A

DE.

**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 *A. H. Anderson*.....

Licensed Embalmer No. *3641*.....

P. O. Address. *Indo.*.....

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

JAN 1

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 272

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

1. PLACE OF DEATH:

(a) County cole  
(b) City or town Jefferson city  
(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) (Specify whether

3. (a) PRINT FULL NAME William Howard  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced, widower  
6. (b) Name of husband or wife Dorothy Reed 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased unk  
(Month) (Day) (Year)

8. AGE: Years 99 Months \_\_\_\_\_ Days \_\_\_\_\_ 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) \_\_\_\_\_ (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) 12-30-43 (b) Norman Bichter  
(Date received 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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 12  
Year 1943 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I 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 (Includes 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 \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

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

S-42053