

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

4817

FILED JAN 21 1944

Registration District No. 377

Primary Registration District No. 6273-6274

Registrar's No.

1. PLACE OF DEATH:

(a) County North  
(b) City or town Rural Middlefork  
(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 1 (Specify whether

In this community Life  
years, months or days)

3. (a) PRINT FULL NAME

William Newton Harding

3. (b) If veteran,  
name war

3. (c) Social Security  
No.

4. Sex MO 5. Color or  
race W

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

6. (b) Name of husband or wife  
Sarah Ellen Harding

6. (c) Age of husband or wife if  
alive 25 years

7. Birth date of deceased Nov 25 1867  
(Month) (Day) (Year)

8. AGE: Years 76 Months 1 Days 8  
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name James H. Harding  
13. Birthplace Unknown Ind.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary A. Williams  
15. Birthplace Unknown Ind.  
(City, town, or county) (State or foreign country)

16. (a) Informant James Harding  
(b) Address Allen Dale Mo

17. (a) Burial (b) Date thereof 1-6-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Isabelle Cemetery

18. (a) Signature of funeral director W. C. Duffer

(b) Address Grant City, Mo

19. (a) 1-7-44 (b) Arline Seaden  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County North  
(c) City or town Rural 113  
(If outside city or town limits, write "RURAL")

(d) Street No. Allen Dale Mo  
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 3  
year 1944 hour 10 minute A 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

Due to cerebral hemorrhage

Due to

Other conditions

(Include 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 Bentley Neal (M. D. or other)

Address Grant City, Mo Date signed 1/5/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1104

(Licensed Embalmer's Statement on Reverse Side)

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**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.....

*Arch C. Duffee*

Licensed Embalmer No.....

*3252*

P. O. Address.....

*Grant City Mo.*

**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.**