

S. No. 2  
M-2-43  
17-39  
X32

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22027

FILED JUL 15 1944

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

Registration District No. \_\_\_\_\_

Primary Registration District No. 3043

Registrar's No. 204

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Leveering Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 0  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Marion 64  
(c) City or town Hannibal 3  
(If outside city or town limits, write "RURAL") 4  
(d) Street No. 804 BIRD  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert Lee Hart

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

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

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

7. Birth date of deceased May 16, 1867  
(Month) (Day) (Year)

8. AGE: Years 76 Months 01 Days 28 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name John Hart

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

14. Maiden name Fannie Gentry

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

16. (a) Informant Hazel Hart

(b) Address 804 Bird Hannibal MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Riverside Cemetery

18. (a) Signature of funeral director James O. Donnell

(b) Address Hannibal MO

19. (a) 6-12-44 (b) R. H. Connor  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1944 hour minute 6:30 P.M.

21. I hereby certify that I attended the deceased from May 14 1944 to May 14 1944 that I last saw him alive on May 14 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Chorea myoclonica

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

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

Other conditions Fractured hip

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, 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 of physician \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 6/17/44

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

1146

(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 Michael J. James

Licensed Embalmer No. 32410

P. O. Address Hamlet, MS

**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. July  
Registrar's No. 204

Registration District No. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:  
(a) County marion  
(b) City or town Hammel  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
3. (a) PRINT FULL NAME Robert Lee Hart  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race W 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 may 16 1954  
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
mo.

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) \_\_\_\_\_ (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) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 may day \_\_\_\_\_  
year 1954 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Chs Myocardial infarct

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

Due to fracture of hip

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 10/11

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident ✓

(b) Date of occurrence May 10 1954

(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? Home ✓

While at work \_\_\_\_\_ (Specify type of place) (f) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address 101 1/2 Perry Street Date signed \_\_\_\_\_

**SUPPLEMENTAL**

FATHER  
MOTHER

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

22027