

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 24450

FILED NOV 13 1944

Registration District No. 2Primary Registration District No. 3028Registrar's No. 211

## 1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Carthage  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: McCune-Brooks Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 5 days (Specify whether  
In this community 70 years  
years, months or days)

3. (a) PRINT FULL NAME Ernest Hart

3. (b) If veteran, name war No 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Edla J. Hart 6. (c) Age of husband or wife if alive - - years  
7. Birth date of deceased September 27 1874  
(Month) (Day) (Year)

8. AGE: Years 70 Months 0 Days 6 If less than one day  
hr. min.

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

10. Usual occupation Retired Farmer11. Industry or business None

MOTHER FATHER  
12. Name John W. Hart  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Everett C. Hart  
(b) Address Carthage, Missouri

17. (a) Burial (b) Date thereof Oct. 5, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery18. (a) Signature of funeral director Knell Mortuary(b) Address Carthage, Missouri

19. (a) Oct. 5 '44 (b) E. Elizabeth Copelin  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49  
(c) City or town Carthage  
(If outside city or town limits, write "RURAL") 3  
(d) Street No. 501 1/2 Grant St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country - - - 0

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3  
year 1944 hour 4:30 minute AM

21. I hereby certify that I attended the deceased from Sept 25, 1944, to Oct 3, 1944,  
that I last saw him alive on Oct 2, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration  
Head Failure

Due to Chronic Brights

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:

(e) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(f) Date of occurrence \_\_\_\_\_  
(g) 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) Means of injury 0

23. Signature J. E. Baker (M. D. or other) \_\_\_\_\_  
Address Carthage, Mo. Date signed 1944

## PHYSICIAN

Underline the cause to which death should be charged statistically.

44-11-912

**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..... *Emm R. Stuep*

Licensed Embalmer No. *391*

P. O. Address *Carthage*

**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. \_\_\_\_\_

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 211

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

1. PLACE OF DEATH

(a) County Jasper

(b) City or town Carthage  
(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 Ernest Haxl

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 w

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

7. Birth date of deceased Sept 27 1884  
(Month) (Day) (Year)

8. AGE: Years 70 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Missouri  
(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 Oct Day 3 Year 1944 Hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

Cerebral Hemorrhage  
Heart Failure

Due to Chronic Bronchitis

Due to Urine Tested for Albumen & History of Care

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

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 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) (a) Means of injury \_\_\_\_\_

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

**SUPPLEMENTARY**

34450