

FILED APR 12 1945

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

Registration District No. 297

Primary Registration District No. 6-2-0446

Registrar's No. 2

1. PLACE OF DEATH:  
(a) County Ray Co  
(b) City or town Hardin Mo  
(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 about 70 years years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County RAY MO  
(c) City or town HARDIN, MO.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mch day 14<sup>th</sup>  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Oct 14 1872 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 14 1872  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jau 1944 to mch 14 1945  
that I last saw her alive on mch 14 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
72 5 0 hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma of Stomach  
Duration 1 year

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

10. Usual occupation Housekeeper

Major findings: Of operations 46 hr  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Melvin S. Noblet  
13. Birthplace Springfield Mo (City, town, or county) (State or foreign country)  
14. Maiden name Mary Bowman  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. O. L. Peters  
(b) Address Jefferson City Mo  
17. (a) Burial (b) Date 3-16-45  
(Funeral, cremation, or removal) (Month) (Day) (Year)  
(c) Place: Hardin Cem

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? \_\_\_\_\_

18. (a) Signature of funeral director John W. Krupich  
(b) Address Hardin Mo  
19. (a) Mar 15 45 (b) Michael Shifford  
(Date received local registrar) (Registrar's signature)

23. Signature Carl H. Reed (M. D. or other)  
Address Hardin Mo Date signed 3/15/45

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

MOTHER FATHER

12 50

RECEIVED

District Health Officer No. 8.

District File Number .....

Date Filed .....

4/10/45

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 *me*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*John W. Knipschild*

Licensed Embalmer No.

*2789*

P. O. Address

*Harlem M*

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. \_\_\_\_\_  
Registrar's No. 2

Registration District No. 297 Primary Registration District No. 4446

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Harden  
(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 \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Nada V. Strider

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 W

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

7. Birth date of deceased Oct 14 (Month) (Day) (Year)

8. AGE: Years 22 Months 5 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Nursekeeper

MOTHER FATHER

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) (Date received local registrar) \_\_\_\_\_ (b) Mrs Shes W. Sheppard (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 March year 1945 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 \_\_\_\_\_

Duration

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

PHYSICIAN

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

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

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

Supplemental

APR 1

10493