

FILED SEP 12 1945

Registration District No. _____

Primary Registration District No. _____

44-7-26088

Registrar's No. ~~286~~ 7

1. PLACE OF DEATH:

(a) County Saline Belle Hardin
 (b) City or town R.F.D. Miami, Mo
 (c) Name of hospital or institution: no
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: _____ (Specify whether)
 In this community: none years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline
 (c) City or town Miami, Mo
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Clara Belle Hardin

3. (b) If veteran, name war. no

3. (c) Social Security No. none

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife. _____

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

7. Birth date of deceased. NOV. 27 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>8</u>	<u>29</u>	_____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business

12. Name Andrew Jackson Shoemaker
 13. Birthplace Penn.
 14. Maiden name Elizabeth Hutton
 15. Birthplace Ind.
 (City, town, or county) (State or foreign country)

16. (a) Informant Raymond Hardin
(b) Address R.F.D. Miami, Mo.

17. (a) burial (b) Date thereof 8-28-'45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation. Rehoboth, Slater,

18. (a) Signature of funeral director Hill Brothers Slater, Mo
(b) Address _____

19. (a) Sept 6 - 1945 (b) Mrs John Giger
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26th
1945 year. hour 8 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 1930, to 8-26, 1945
that I last saw him alive on 8-25, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis

Duration about 1 1/2 years

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) psd

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature A. J. Sullivan (M. D. or other) M.D.
Address Miami Mo. Date signed 8/26/45

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

MOTHER FATHER

1211

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 9-10-45

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 _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Sam M. Hill

Licensed Embalmer No. 1292

P. O. Address States 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.