

FILED MAY 27 1946

Registration District No. _____

Primary Registration District No. **4514**

Registrar's No. **7**

1. PLACE OF DEATH:

(a) County *Sullivan*
(b) City or town *Green City, 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 *Life* years, months or days _____

3. (a) PRINT FULL NAME *Chloe Delia Hardinger*

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 *M.*
6. (b) Name of husband or wife *Thomas Hardinger* 6. (c) Age of husband or wife if alive *65* years
7. Birth date of deceased *3-10-1889*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 *0* *28* hr. min.

9. Birthplace *Sullivan Co. Mo.*
(City, town, or county) (State or foreign country)

10. Usual occupation *Housewife*

11. Industry or business _____

MOTHER FATHER { 12. Name *Leonard Pierce*

13. Birthplace *N.Y.*
(City, town, or county) (State or foreign country)

14. Maiden name *Ellen B. Riddle*

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

16. (a) Informant *J. S. Hardinger*

(b) Address *Green City, Mo.*

17. (a) *Burial* (b) Date thereof *4-10-1946*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Mt. Olivet Cem.*

18. (a) Signature of funeral director *Glenn E. Feil - Son*

(b) Address *Green City, Mo.*

19. (a) *5-2-46* (b) *Clara M. Shaw*
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Sullivan*
(c) City or town *Green City*
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? *No.* (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* day *8th*
year *1946* hour *8:30* minute *A.* M.

21. I hereby certify that I attended the deceased from *Jan 1*
1946, to *April 8*, 19*46*
that I last saw *her* alive on *April 8*
and that death occurred on the date and hour stated above.

Immediate cause of death *ADVANCED*
CARCINOMA OF CHEST
BREAST AND LUNGS

Due to _____
Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

Duration
6 years.

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)
(c) Means of injury _____
23. Signature *J. C. Shure* (M. D. or other)
Address *Green City, Mo.* Date signed *4-9-46*

FEB 20 1948

RECEIVED
District Health Officer No. 1
District File Number 5-46-16
Date Filed MAY 23 1946

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address. Green Hill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. Temp

Registration District No. 349

Primary Registration District No. 4514

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Sullivan
 (b) City or town Green city
 (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 Chloe D. Hardinger

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 m

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

7. Birth date of deceased mar 10
 (Month) (Day) (Year)

8. AGE: Years 57 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ Year 194 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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, _____

CARCINOMA OF RIGHT BREAST

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy 50

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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