

No. 2
5-43
E-17-39
X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1601**

FILED JAN 21 1947

Registration District No. **164**

Primary Registration District No. **3032**

Registrar's No. **2**

1. PLACE OF DEATH:

(a) County **Johnson.**

(b) City or town **Warrensburg.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Warrensburg Clinic.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 da.**
(Specify whether years, months or days)

In this community **21 yrs.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**

(c) City or town **Warrensburg.**
(If outside city or town limits, write "RURAL")

(d) Street No. **701, Broad**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Hildreth Paul Harding.**

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

3. (c) Social Security No. **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **6**
year **1947** hour **8** minute **45** A.M.

21. I hereby certify that I attended the deceased from **1-1-47**
to **1-6**, 19**47**
that I last saw him alive on **1-6**, 19**47**
and that death occurred on the date and hour stated above.

4. Sex **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife **Nettie Harding**

6. (c) Age of husband or wife if alive **37** years

7. Birth date of deceased **May. 14, 1904**
(Month) (Day) (Year)

Duration **6 days**

Immediate cause of death **Cerebral laceration**

Due to **Accidental trauma due to auto-train accident**

Due to.....

8. AGE:

Years	Months	Days	If less than one day
42	7	23hr.min.

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

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

10. Usual occupation **Feed Store.**

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

1706.8
1793

Underline the cause to which death should be attributed.

11. Industry or business.....

12. Name **C. E. Harding.**

13. Birthplace **Perry Co. Ind.**
(City, town, or county) (State or foreign country)

14. Maiden name **Minnie Davis.**

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

16. (a) Informant **Nettie Harding.**

(b) Address **Warrensburg, MO.**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **1/8/47.**
(Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Hill Cem.**

18. (a) Signature of funeral director **Sweeney Phillips.**

(b) Address **Warrensburg, MO.**

19. (a) **Jan. 7, 1947** (Date received local registrar)

(b) **Sarah Ann C. Phillips** (Registrar's signature)

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 **R. L. Leeper** (M. D. or other)

Address **Warrensburg Mo**

Date signed **1-7-46**

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

MOTHER FATHER

147

MAR 25 1947

8:45

JAN 9 01947

DEPT. OF HEALTH

JAN 28 1947

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 J. Earl Priest

Licensed Embalmer No. 2878

P. O. Address. Warrensburg 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.

Registration District No. 164 Primary Registration District No. 3032

1. PLACE OF DEATH

(a) County Johnson
(b) City or town Warrensburg
(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 Heldreth P. Harding

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 m

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

7. Birth date of deceased may 14 1930
(Month) (Day) (Year)

8. AGE: Years 42 Months 7 Days 3 If less than one day _____ hr. _____ min.

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) _____ (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) _____ (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 1947 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 _____

Due to _____

Due to _____

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

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) accident

(b) Date of occurrence 1-1-47

(c) Where did injury occur? Warrensburg Johnson mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on railroad crossing

While at work? no (Specify type of place) (e) Means of injury Car & train

23. Signature P. Heel Cooper (M. D. or other) mo

Address Warrensburg mo Date signed 1-29-47

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

SUPPLEMENTARY

S-1601