

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis,**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Anthony
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 Weeks**
(Specify whether years, months or days)

In this community **Years**

3. (a) PRINT FULL NAME **James L. Hardie**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **Nov. 12 1873**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
73	8	9	hr. _____ min. _____

9. Birthplace **County Tyrone Ireland**
(City, town, or county) (State or foreign country)

10. Usual occupation **President**

11. Industry or business **Hornbeck & Hardie Elec. Co.**

MOTHER FATHER

12. Name **Joseph Hardie**
 13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
 14. Maiden name **Margaret Burrows**
 15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Genie M. Hardie**
 (b) Address **512 Bellerive Blvd.**

17. (a) Burial (b) Date thereof **July 24 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **C. Hoffmeister Colonial Mortuary**
 (b) Address **6464 Chippewa St.**

19. (a) III 21 1947 (b) **F. Kudack**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **osw**
 (c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
 (d) Street No. **512 Bellerive Blvd.** **9**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____ **Naturalized abt. 1910**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **21**
 year **1947** hour **4:00** minute _____ A.M.

21. I hereby certify that I attended the deceased from **June 2**
1947 to **July 30** 19**47**
 that I last saw him alive on **July 19** 19____
 and that death occurred on the **date** and hour stated above.

Immediate cause of death **Carcinoma of sigmoid upper** **1 yr + ?**

Due to _____
 Due to _____

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

Major findings: **above**
 Of operations _____
 Of autopsy _____

Duration _____
 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 **Dubrain J. Burke** (M. D. or other) **md**
 Address **5203 Chippewa** Date signed **7-26-47**

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 *Harry J. Schumacher*
Licensed Embalmer No. *2679*

P. O. Address *7514 F. Broadway*

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.