6. No. 2
(—1/47
5-17-39

WHITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 20 1947

Registration District No. 2

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28684

Primary Registration District No. 3056

Registrar's No. 187

1. PLACE OF DEATH:
(a) County: Randolph
(b) City or town: Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wabash Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Randolph
(c) City or town: Moberly
(If outside city or town limits, write "RURAL")
(d) Street No.: 215 College
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

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3. (a) PRINT FULL NAME: CARSON WALTER HARDISTER
3. (b) If veteran, name war .....
3. (c) Social Security No.: 702-05-3347
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Carrie
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: July (Month) 27th (Day) 1873 (Year)

8. AGE: Years	Months	Days	If less than one day
74	—	13	..... hr. ..... min.

9. Birthplace: Mo (City, town, or county) (State or foreign country)
10. Usual occupation: Rtd
11. Industry or business: Wabash RR
FATHER
12. Name: Frank Hardister
13. Birthplace: Ky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Ella Broadus
15. Birthplace: Ky (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Carrie Hardister
(b) Address: Moberly
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-13-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Moberly
18. (a) Signature of funeral director: Mahan and Son
(b) Address: Moberly Mo
19. (a) Aug 13-47 (Date received by local registrar) (b) Leah Williams Lowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10 year 1947 hour 4:05 minute A M.

21. I hereby certify that I attended the deceased from 8/9, 1947 to 8/10, 1947 that I last saw him alive on 8/10, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	20 minutes
Due to: Arteriosclerotic heart disease	5 years (?)
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: 93
Of autopsy:

PHYSICIAN
Underline the cause of 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? ..... (Specify type of place) ..... While at work? ..... Means of injury .....

23. Signature: [illegible] (M. D. or other) Mo
Address: Wabash Hospital Date signed Aug 16 47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 1
District File Number 8-47-106
Date Filed AUG 19 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.....

Licensed Embalmer No.....

P. O. Address.....

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.