

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3571

BIRTH NO.		REG. DIST. NO. 317	PRIMARY REG. DIST. NO. 6076	Registrar's No. 63
1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY AAO		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Koch (rural))		c. CITY (If outside corporate limits, write RURAL and give township) 17 OR TOWN St. Louis 5		
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		d. STREET ADDRESS (If rural, give location) 407 South Ewing		
3. NAME OF DECEASED (Type or Print) a. (First) JOHN		b. (Middle)		c. (Last) HARDY
4. DATE OF DEATH January 7 1949				
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH April 15, 1903	9. AGE (In years last birthday) 45 IF UNDER 1 YEAR: Months 8 Days 23 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY American Thermometer		11. BIRTHPLACE (State or foreign country) Co. Columbus, Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13a. FATHER'S NAME Dan Hardy		13b. MOTHER'S MAIDEN NAME Retha Blanks		14. NAME OF HUSBAND OR WIFE Anna Mae Wilson Hardy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hosp. Records, Robert Koch Hosp., Koch, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 136 102		INTERVAL BETWEEN ONSET AND DEATH (11)
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 3/19 , 19 48 , to 1/7 , 19 49 , that I last saw the deceased alive on 1/7 , 19 49 , and that death occurred at 1:40 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) John R. Beem, M.D.		23b. ADDRESS Robert Koch Hospital		23c. DATE SIGNED 1.7.49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 12/1949		24c. NAME OF CEMETERY OR CREMATORY Father Dickson
24d. LOCATION (City, town, or county) Kirkwood, Missouri				
DATE REC'D BY LOCAL REG. 1/12/49		REGISTRAR'S SIGNATURE Thurid V. Lininger, M. D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. A. Sheen 4214 Selman

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

F. A. Green

Signed _____

Student Embalmer

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.