

FILED FEB 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4648**

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023** Registrar's No. **59**

522
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) Clinton		c. CITY (If outside corporate limits, write RURAL and give township) Collins (Rural Doyal Twp.)	
c. LENGTH OF STAY (in this place) 4 days		d. STREET ADDRESS (If rural, give location) 0930	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wetzel Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Dessie		b. (Middle) --	
c. (Last) Hardy		4. DATE OF DEATH 2/20/1950 (Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9/13/1888
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR 5 Days	IF UNDER 24 HRS. 7 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Clair County Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Allen		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Amos Hardy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No (If yes, give war and date of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Amos Hardy Collins Mo. ADDRESS	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) Cerebral Hemorrhage		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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.		331X	
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) (Min.)		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 2/16 10:50 , to 2/20 1950 , that I last saw the deceased alive on 2/20 , 1950, and that death occurred at 8:30P m., from the causes and on the date stated above.	
23a. SIGNATURE R. Mark Todd (Degree or title)		23b. ADDRESS Osceola, Mo.	
23c. DATE SIGNED 2/21/50		24a. BURIAL CREMATION REMOVAL (Specify) Burial	
24b. DATE 2/22/50		24c. NAME OF CEMETERY OR CREMATORY Osceola	
24d. LOCATION (City, town, or county) (State) Osceola Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Florence Adams ADDRESS Osceola Mo	
DATE REC'D BY LOCAL REG. Feb. 21-50		REGISTRAR'S SIGNATURE Florence Adams	

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RECEIVED
District Health Officer No. 7,
District File Number 1-50-121
Date Filed 2-27-50

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.

Student
Student Embalmer

Signed Ray Miller

Licensed Embalmer No. 4492

P. O. Address Oscola, 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.