

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28486

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6249

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 3636 Page 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Marie		b. (Middle)	
c. (Last) Hardrick		7 1 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) Ab. 74		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Columbia, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Tom Gentry		13b. MOTHER'S MAIDEN NAME Dora Akers	
14. NAME OF HUSBAND OR WIFE Dead		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Edwards 4591 St. Ferdinand Ave.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Breast, Rt. INTERVAL BETWEEN ONSET AND DEATH Undet. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Chronic Cholecystitis & Cholelithiasis Cardiovascular Accident	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		170X	
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) m.	
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 5-25-1956, to 7-1-1956, that I last saw the deceased alive on 7-1-1956, and that death occurred at 1:55 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Hugh Watson		23b. ADDRESS M. D. 2601 N. Whittier	
23c. DATE SIGNED 7-2-56		24. BURNAL, CREMATION, REMOVAL (Specify) Removal (R.R.)	
24b. DATE 7/3/56		24c. NAME OF CEMETERY OR CREMATORY Springfield, Mo.	
24d. LOCATION (City, town, or county) (State) Springfield, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.W. Roberts 1416 N. Taylor Ave.	
DATE REC'D BY LOCAL REG. JUL 3 1956		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

