FILED FEB 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 152

Registration District No. 15 Primary Registration District No. 3004 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY: BARTON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: LAMAR — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARTON CO MEMORIAL — Length of stay in 1b: 5 MONTH

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: BARTON
c. CITY OR TOWN: MILFRED — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: JOSEPHINE Middle: SUSIE Last: HARDESTY
4. DATE OF DEATH: Month JAN Day 20 Year 1957
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC 1 1907
9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months 1 Days 20 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): EARLY IOWA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ROBERT WILLIAM HARDESTY
14. MOTHER'S MAIDEN NAME: –
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Roy Hardesty Address: Milfred Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) carcinoma of cervix — INTERVAL BETWEEN ONSET AND DEATH: Dec. 24, 1955
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) generalized metastasis to bladder and bowel — Aug., 1956
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
anaplastic squamous cell carcinoma 171X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 3
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Dec. 24, 1955, to Jan. 20, 1957 and last saw her/him alive on Jan. 20, 1957
Death occurred at 11:25 AM m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Ben T. Buckel (Degree or title) M.D.
22b. ADDRESS: Lamar, MO.
22c. DATE SIGNED: 1/27/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan 22-1957
23c. NAME OF CEMETERY OR CREMATORY: Howell Cemetery
23d. LOCATION (City, town, or county) (State): Barton Co Mo
24. FUNERAL DIRECTOR: S. Bernard Bury ADDRESS
25. DATE REC'D. BY LOCAL REG.: JAN 30 '57
26. REGISTRAR'S SIGNATURE: Marie Konantz

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in filling out symptoms and diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

FEB 6 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed S. Bernard Berry

Licensed Embalmer No. 41

P. O. Address Sheldon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.