

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5931

FILED MAR 7 1957

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 61

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Flat River			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Flat River		0942 0	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At. Home			Length of stay in lb	d. STREET ADDRESS 500 W Main			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Barney Middle h Last Hart				4. DATE OF DEATH Month Feb. Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/7/1895	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Month 3 Days 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest			10b. KIND OF BUSINESS OR INDUSTRY Mfg	11. BIRTHPLACE (City and state or country) Flat River, Mo /		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Smith B. Hart				14. MOTHER'S MAIDEN NAME Margaret McClarney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 1			16. SOCIAL SECURITY NO. 286 18 721	17. INFORMANT Address Edythe Hart Flat River, Mo			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumo-pneumonia DUE TO (b) Cor. pulmonale DUE TO (c) Pneumonia - bacterial - emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 7 days 25 yrs	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 241X				
20c. TIME OF INJURY Hour Month Day Year a. m. p. m. 			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 May 56 to Feb 20-57 and last saw her alive on 2-19-57 Death occurred at 10:00P on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) A. D. Rudloff M. L.				22b. ADDRESS Desloge, Mo		22c. DATE SIGNED 2-27-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/23/1957	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) Flat River, Mo		(State)	
24. FUNERAL DIRECTOR ADDRESS Boyer & Son Desloge, Mo			25. DATE RECD. BY LOCAL REG. Feb 21, 1957		26. REGISTRAR'S SIGNATURE Esther Rudloff		

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare Public Service
 0942
 300 7-56
 Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms written by listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAR 18 1951

REAR

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 Signature of Student Embalmer

Signed *B. T. Bayer*

Licensed Embalmer No. *30*

P. O. Address *Leola*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.