

Health,
Welfare
Public
Service

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
300

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 980

300
-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1403 1/2 N. 2nd Street</u>		Length of stay in 1b <u>40 yrs.</u>	d. STREET ADDRESS <u>1403 1/2 N. 2nd St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Lee</u> Last <u>Harding</u>			4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1957.</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 21, 1883</u>	9. AGE (In years last birthday) <u>74</u>	F UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Time keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armour & Co.</u>	11. BIRTHPLACE (City and state or country) <u>Buchanan Co., Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>William Harding</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Rambeau</u>		14. NAME OF HUSBAND OR WIFE <u>Nora E. Harding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>500-09-6574</u>	17. INFORMANT <u>Mrs. Lucille Florine St. Joseph, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Carcinomatosis</u> <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u>Primary Carcinoma of the colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Over 6 mos.</u> <u>Over 1 yr.</u>
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.) <u>153X</u>			
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED WHILE AT <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 <u> </u>	STATE <u> </u>
21. I attended the deceased from <u>6/9/47</u> to <u>9/6/57</u> and last saw her alive on <u>9/6/57</u> Death occurred at <u>3:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robert Fulton</u> (Degree or title)			22b. ADDRESS <u>218 N. Seventh, St. Joseph, Mo.</u>		22c. DATE SIGNED <u>9/11/57</u>
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 11, 1957.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri.</u>	
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>September 13, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DEC 11 1957

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 *Albert G. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.