

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008930

STATE FILE NUMBER

Health,
Welfare
Public
Service

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-57

FILED MAR 18 1959 Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <i>Dunklin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Dunklin</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kennett</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kennett</i> c-352 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Dunklin Co. Memo Hosp.</i>		Length of stay in 1b <i>2 yrs</i>	d. STREET ADDRESS (If outside, give location) <i>408 E. Washington</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Henry</i> Last <i>Hardy</i>			4. DATE OF DEATH Month <i>Feb</i> Day <i>27</i> Year <i>1959</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 10, 1884</i>		9. AGE (In years, last birthday) <i>74</i> MONTHS <i>3</i> DAYS <i>17</i> IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Section crew worker</i>	10b. KIND OF BUSINESS OR OCCUPATION <i>Canon Belt Railroad</i>	11. BIRTHPLACE (City and state or country) <i>Vernon, Alabama</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13a. FATHER'S NAME <i>William H. Hardy</i>		13b. MOTHER'S MAIDEN NAME <i>Sarah L. Johnson</i>		14. NAME OF HUSBAND OR WIFE <i>Diva Mae Hardy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or other) (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Mrs. Diva Mae Hardy</i> Address <i>408 E. Washington Kennett, Mo.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adrenal insufficiency</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Metastatic Carcinoma of Prostate</i>		
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
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 <i>Feb 17, 1959</i> to <i>Feb 27-59</i> and last saw him alive on <i>Feb 27. 59</i> Death occurred at <i>5:15 A. M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Leo Benson MD - c</i>		22b. ADDRESS <i>Kennett Mo</i>		22c. DATE SIGNED <i>3/11/59</i>	

23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/2/59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gainesville Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Gainesville, Ark.</i>	
24. FUNERAL DIRECTOR'S ADDRESS <i>Howard Funeral Service - Beachville, Ark.</i>			25. DATE RECD. BY LOCAL REG. <i>3-12-1959</i>		26. REGISTRAR'S SIGNATURE <i>Lois Husband</i>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

MAR 31 1950

COUNTY FILE NUMBER 339-87

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 Monte Brines

Licensed Embalmer No. 5032

P. O. Address... Lachvillo

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.