

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SEP 15 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

29038

1. PLACE OF DEATH

County Henry
Township Clinton
City Clinton

Registration District No. 347
Primary Registration District No. 5018
(No. 703 No Third

File No. _____
Registered No. #109
St. _____ Ward)

2. FULL NAME Grace Truman Hord

(a) Residence, No. 703 North Third St., _____ Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

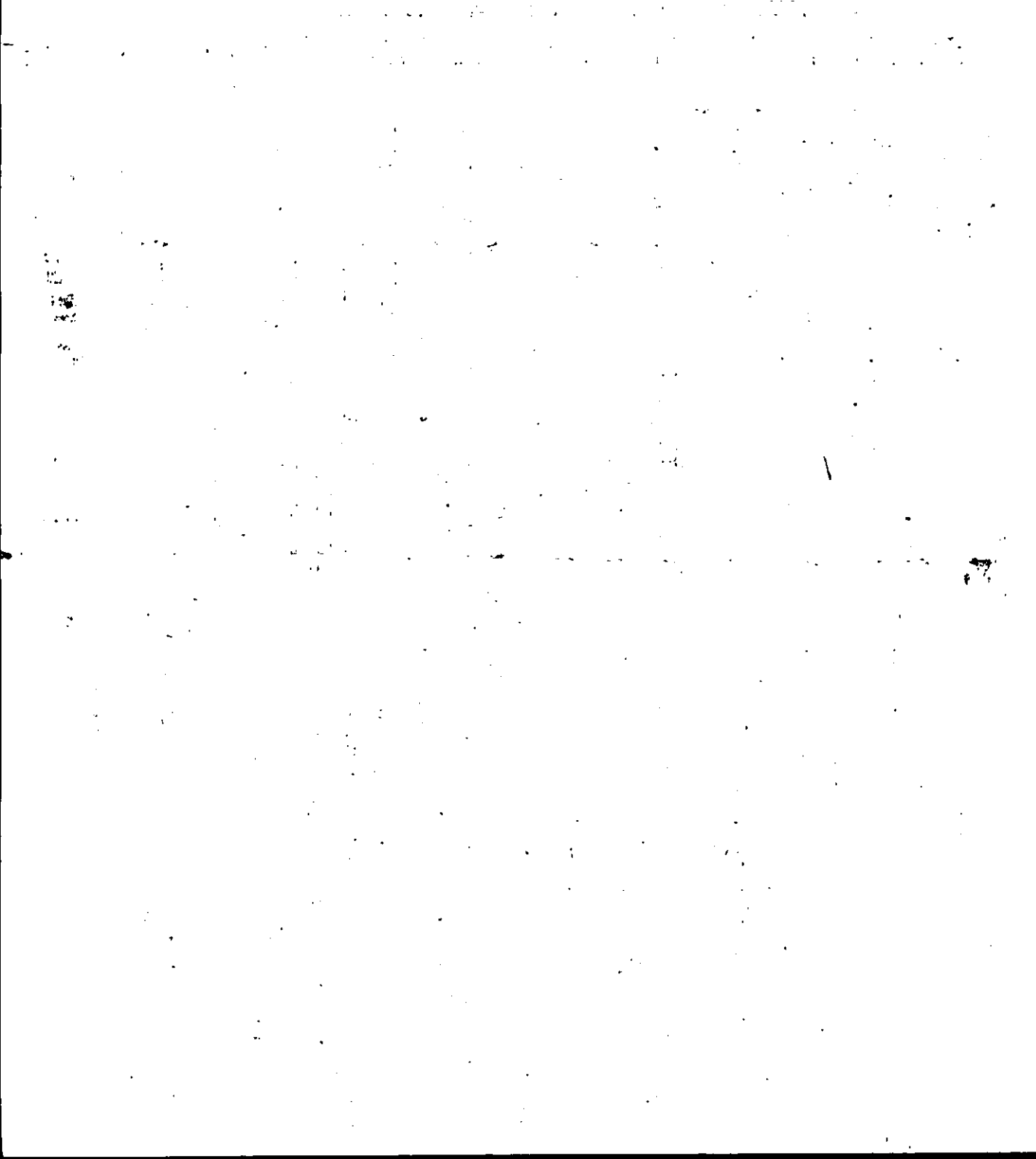
PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|----------------------------------|---|
| 3. SEX Female | 4. COLOR OR RACE White | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Benjamin E. Hord | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 20, 1871 | | |
| 7. AGE 63 | YEARS 2 | MONTHS 26 |
| 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife | | 11. Total time (years) spent in this occupation |
| 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. | | 10. Date deceased last worked at this occupation (month and year) |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson County Missouri | | |
| 13. NAME Unknown | | |
| 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown | | |
| 15. MAIDEN NAME Unknown | | |
| 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown | | |
| 17. INFORMANT Benjamin E. Hord, Clinton, Missouri | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE Englewood DATE Aug. 17, 1934 | | |
| 19. UNDERTAKER (ADDRESS) Sims Funeral Home Clinton, Missouri | | |
| 20. FILED 8-17-34 J. R. Haverstick Registrar | | |

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 15, 1934

22. I HEREBY CERTIFY, That I attended deceased from July, 1934, to Aug 15, 1934
I last saw her alive on Aug 15, 1934. Death is said to have occurred on the date stated above, at 12 p.m.
The principal cause of death and related causes of importance were as follows:
Chronic pulmonary tuberculosis
Date of onset 1924
1868
1948
Other contributory causes of importance:
Latent-Case of fracture Aug 1/34
Name of operation None Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) S. B. Hughes, M. D.
(Address) Clinton, Mo.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Hampton

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County *Henry*
Township *Clinton*
City *Clinton*

Registration District No. *347*
Primary Registration District No. *3018*

File No. *29038*
Registered No. *109*
St. _____ Ward _____

2. FULL NAME

Grace Thurmon Hard

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *f* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *m*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 2 26

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS) _____

20. FILED *8-11* 19*34* *J. R. Hampton* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 15 1934*

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____.
I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Chronic pulmonary tuberculosis
Date of onset _____
Other contributory causes of importance: *rib-capsular fracture*

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *Accident* Date of injury *Aug 5, 1934*
Where did injury occur? *Clinton, Mo.*
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. *In home*

Manner of injury *fell on floor*
Nature of injury *rib-capsular fracture*

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) _____, M. D.
(Address) _____

SUPPLEMENTARY

JAN 3 0 1935

S-29038