

7570 OCT 13 1939

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

33017  
Do not use this space.

1. PLACE OF DEATH

(a) County Monterey 2 Registration District No. 571  
 (b) Township Walter 1 Primary Registration District No. 21  
 or California  
 (c) City California (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. 17 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Harry Hare

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 10 - 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
89 5 24

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as 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) Monticue Co Mo

FATHER

13. NAME Harry Hare C  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER

15. MAIDEN NAME Caroline Marshall  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Key

17. INFORMANT Geo Hare  
 (ADDRESS) California

18. BURIAL CREMATION, OR REMOVAL PLACE Old Salem DATE 9/6 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hellmeyer & Son  
California

20. FILED 9-5-39 H.R. Popejoy  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-4-1939

22. I HEREBY CERTIFY, That I attended deceased from For several years 19\_\_\_\_ to 19\_\_\_\_.

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 9:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma Rectum Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Chronic Diabetes

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? \_\_\_\_\_ 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) Larkley M. Gray, M. D.  
 (Address) California

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.

MARGIN RESERVED FOR BINDING

V. S. NO. 2.  
30M-9-19-38  
I X16603

RECORDS  
DEPT. OF HEALTH  
DIVISION OF PUBLIC HEALTH  
STATE OF CALIFORNIA

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed HE Friedmeyer  
Licensed Embalmer No. 2854  
P. O. Address California 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 this body is not embalmed, above space should be left blank.**

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. PHYSICIAN'S 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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

33017

Do not use this space.

1. PLACE OF DEATH

(a) County Moniteau Registration District No. 871  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4335 Registered No. 46  
 (c) City California (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) <u>wid</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)			
7. AGE	YEARS	MONTHS	DAYS
	<u>89</u>	<u>5</u>	<u>24</u>
If LESS than 1 day, _____ hrs. or _____ min.			
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
	9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)			
20. FILED <u>9-5-39</u> <u>N.R. Popejoy</u> Local Registrar.			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-4-1939

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:

Date of onset

Other contributory causes of importance:

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? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
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24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) L. M. Gray, M. D.  
 (Address) California

SUPPLEMENTARY

