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.

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

**PLACE OF DEATH**

County: Polk

Township: ~~[illegible]~~ or Village: or City: Bolivar (NO. ____, ____ St.; ____ Ward)

Registration District No. 701 — File No. 27 — 32117

Primary Registration District No. 4422 — Registered No. 48

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** William Hale

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | Widowed |

DATE OF BIRTH: October (Month) 30 (Day), 1827 (Year)

AGE: 86 yrs. ____ mos. 29 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ——

BIRTHPLACE (City or town, State or foreign country): Not Known

PARENTS
- NAME OF FATHER: Tom Hale
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known
- MAIDEN NAME OF MOTHER: " "
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. D. Wright

(ADDRESS) Bolivar Mo.

Filed Nov 30, 1913. J. F. Roberts, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: November (Month) 29 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov-25, 1913, to Nov 29, 1913, that I last saw h. alive on Nov-27, 1913, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
Caused by
Arterio Sclerosis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. P. Mitchell M. D.

Nov-29, 1913 (Address) Bolivar Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Greenwood Cemetery, Bolivar — DATE OF BURIAL: Nov. 30, 1913

UNDERTAKER: N. B. Yeley — ADDRESS: Bolivar Mo.

Mitchell

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

**PLACE OF DEATH**

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... , ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** .....

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.

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

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

..... , 1..... (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... , 191..... , .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , 191..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ..... , 191..... , to ..... , 191..... , that I last saw h..... alive on ..... , 191..... , and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... , 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... , 191..... |
|---|---|
| UNDERTAKER | ADDRESS |