LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

17970

PLACE OF DEATH

County Jasper — Registration District No. 408 — File No.

Township — Primary Registration District No. 3020 — Registered No.

City Carthage (No. ..., ... St. ... Ward)

FULL NAME Hall

(a) Residence. No. 123 Elm St., ... Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	single

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR) June 29 1924

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, 12 hrs. or ... min.

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

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

(c) Name of employer ✓

BIRTHPLACE (CITY OR TOWN) Carthage (STATE OR COUNTRY) Mo

10. NAME OF FATHER Clyde M Hall

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Greenfield (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Myrtle I Foster

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lamar (STATE OR COUNTRY) Mo

INFORMANT Mrs Myrtle I Hall (Address) Carthage Mo

FILED June 30 1924 S B Clinton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 1924

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1924, to June 29, 1924, that I last saw her alive on June 29, 1924, and that death occurred, on the date stated above, at 10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Premature birth

1 ... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) none

... (duration) ... yrs. ... mos. ... ds.

16 lb

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ✓

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) H A La Force, M.D

June 30 1924 (Address) Carthage Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Park Cemetery — DATE OF BURIAL June 30 1924

20. UNDERTAKER C. Hall Father of Baby — ADDRESS Carthage

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... St. ..... Ward

2. FULL NAME .....

(a) Residence. No..... 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19..
that I last saw h..... alive on....., 19....., and
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.