

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

Do not use this space.

15167

1. PLACE OF DEATH

Country Jackson Registration District No. **399**
Township H. 1st Primary Registration District No. **1002**
City St. Louis (No. 1820 Agnes

File No. _____
Registered No. 2035
St. _____ Ward)

2. FULL NAME

George M. Hale
(a) Residence, No. 1820 Agnes 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Jorie Hale

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 17 - 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 3 13

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) St. Louis

10. NAME OF FATHER H. M. Hale

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

12. MAIDEN NAME OF MOTHER Jane Taylor

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

14. INFORMANT Jorie Hale (Address) 1820 Agnes

15. FILED May 18, 1927 M. M. Crave REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 1927

17. I HEREBY CERTIFY, That I attended deceased from 5:11 27, 1927, to 5:17, 1927, that I last saw him alive on 5:16, 1927, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH WAS AS FOLLOWS:

Influenza

11B 17 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 11B (duration) yrs. mos. da.

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) J. R. Keall, M. D.

(Address) 515 1/2 E. Lathrop Bldg

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cherokee DATE OF BURIAL May 19, 1927

20. UNDERTAKER Rose & Co - 15 Jackson ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state cause of death EXACTLY.

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