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: Gentry

Township: ~~Cooper~~

or Village:

or City: Stanberry Mo (NO. Malina St.: Ward)

Registration District No. 314

Primary Registration District No. ~~54293~~ 4190

File No. 16748

Registered No. 15

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

FULL NAME: ~~Mrs. Malina~~ R. Hall. Malina R. Hall

PERSONAL AND STATISTICAL PARTICULARS

SEX: F.

COLOR OR RACE: W.

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married wife of William L. Hall

DATE OF BIRTH: Sept. (Month) 2 (Day), 1856 (Year)

AGE: 71 yrs. 8 mos. 18 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Adams Co. Ohio.

PARENTS

NAME OF FATHER: Richard J. Westfrook

BIRTHPLACE OF FATHER (City or town, State or foreign country): Adams Co. Ohio.

MAIDEN NAME OF MOTHER: Elizabeth Head

BIRTHPLACE OF MOTHER (City or town, State or foreign country): N. Y.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mr. Wm L. Hall

(ADDRESS): Stanberry Mo R.F.

Filed 5/23, 1928 C S Bernat REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 20 (Day), 1928 (Year)

I HEREBY CERTIFY, that I attended deceased from 5/5, 1928, to 5/20, 1928, that I last saw her alive on 5/19, 1928, and that death occurred, on the date stated above, at 845 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease 92A

900

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

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

(Signed) Jas. A. Crockett M. D.

5/21, 1928 (Address) Stanberry, 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: High Ridge Cemetery Stanberry Mo

DATE OF BURIAL: 5/22, 1928

UNDERTAKER: Laton F. Phillips

ADDRESS: Stanberry Mo

1928-12-20
1856-9-2
77 8-18

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.

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