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

File No. 16749

Registration District No. 314

Primary Registration District No. 4190

Registered No. 16

PLACE OF DEATH

County: Gentry

Township or Village: Cooper

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

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

FULL NAME William Lincoln Hall

PERSONAL AND STATISTICAL PARTICULARS

SEX: M.

COLOR OR RACE: W.

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widower husbank

DATE OF BIRTH: Sept. 21st, 1854 (Month) (Day) (Year)

Malina R. Hall deceased

AGE: 73 yrs. 8 mos. 2 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): Lincoln Illinois

PARENTS

NAME OF FATHER: William F. Hall

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

MAIDEN NAME OF MOTHER: unk

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Thelma Waldo

(ADDRESS) Stanberry Mo

Filed 5/30, 1928 C S Bennett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May 23, 1928 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 22, 1928, to May 23, 1928, that I last saw him alive on May 23, 1928, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

108 Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (SECONDARY) .....

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

(Signed) S. E. Simpson M. D.

..... 191.... (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: Stanberry Mo

DATE OF BURIAL: 5/26, 1928

UNDERTAKER: Lafon F. Phillips

ADDRESS: Stanberry Mo

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

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____ _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

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

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.