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

Do not use this space.

34619

1. PLACE OF DEATH
County Pemiscot Registration District No. 661
Township Little Prairie Primary Registration District No. 4388
City Caruthersville (No. ..... St. ..... Ward)

File No. .....
Registered No. 140

2. FULL NAME Donald Halley
(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
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): July 2-1920
7. AGE: Years 9 Months 3 Days 14 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): Mo
PARENTS
10. NAME OF FATHER: Sil Guster Halley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ind
12. MAIDEN NAME OF MOTHER: Mosouri Goad
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
14. INFORMANT: Sil Guster Halley
(Address) Caruthersville Mo
15. FILED Oct. 18, 1929 Ada Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 10-16 1929
17. I HEREBY CERTIFY, That I attended deceased from 10/6, 1929 to 10/15, 1929 that I last saw him alive on 10/14, 1929, and that death occurred, on the date stated above, at 5 p m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
133A Nephritis
130
135B (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): Cystitis Pyelitis
..... (duration) ..... yrs. ..... mos. ..... ds.
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) B McKinney, M. D.
10/17, 1929 (Address) Caruthersville 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Maple Cemetery
DATE OF BURIAL: 10-17 1929
20. UNDERTAKER: H S Smith
ADDRESS: Cville Mo

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.