

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

Do not use this space.

1845

1. PLACE OF DEATH

County *Mc Donald* Registration District No. *1149*
Township *Lanagan Pincille* Primary Registration District No. *5698*
City *Lanagan* (No.) St. Ward

File No. *3*
Registered No. *22*

2. FULL NAME

John - Halling
(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) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Cordelia Halling*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 8 - 1844*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 8 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Retired Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Pittsburg Penn*
(STATE OR COUNTRY)

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 *Cordelia Halling*
(Address) *Lanagan*

15. FILED *1/29 1930* *Ed O'Connell*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 25 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 11* 1930 to *Jan 25* 1930 that I last saw him alive on *Jan 24* 1930, and that death occurred, on the date stated above, at *11* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic nephritis with
acute insult*

131 92A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *131 92A* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF *✓*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Chest*

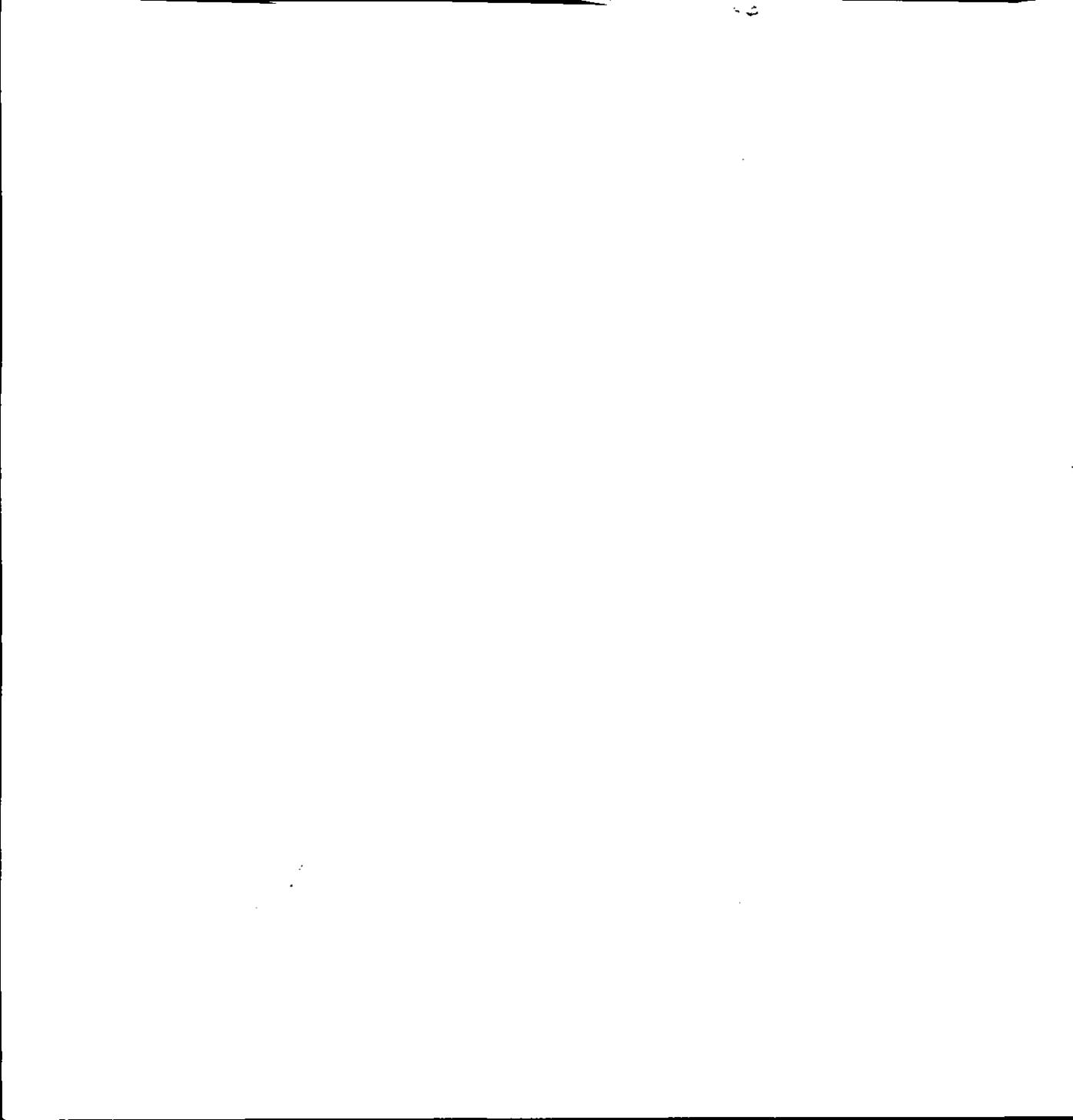
(Signed) *W. H. Norton* M. D.

, 19 (Address) *Pincille 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 *Anderson Cemetery* DATE OF BURIAL *1/26 1930*

20. UMBERTAKER *C. L. Casnell* ADDRESS *Pincille Mo*



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County McDonald Registration District No. 1149 File No. _____
 Township Lanogan Primary Registration District No. 3-698 Registered No. 22
 City Lanogan (No. _____) St. _____ Ward _____

2. FULL NAME John Halling
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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.
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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) _____

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, 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.

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. D.
 _____, 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.

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

14. INFORMANT _____ (Address) _____

15. FILED 1/18/30 Lee Leavelle REGISTRAR

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH
 SUPPLEMENTARY

S-1845