

APR 28-1930

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

Do not use this space.

## 1. PLACE OF DEATH

County *Christian*Registration District No. *181*Township *POIK*Primary Registration District No. *5257*

City.....

(No.....)

File No. *8058*

Registered No.....

St..... Ward)

## 2. FULL NAME

*Andrew Jackson Hale*

(a) Residence. No.....

St..... Ward.....

(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

*Martha Hale*

## 6. DATE OF BIRTH (MONTH, DAY AND YEAR)

*Sept. 9 1878*

## 7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1

*51**6**9*day, ..... hrs.  
or ..... min.

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

*farmer*

(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.*

## 10. NAME OF FATHER

*Joseph Hale*

## 11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Mo.*

## 12. MAIDEN NAME OF MOTHER

*Mary Cavener*

## 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Mo.*

## 14.

INFORMANT

(Address)

*William Scruggs**Cherry gro*

## 15.

FILED

19

*3/11 30 J. H. Brower*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 18 1930*

## 17.

I HEREBY CERTIFY, That I attended deceased from *Mar 10*, 19*30* to *Mar 18*, 19*30* that I last saw him alive on *Mar 18, 1930*, and that death occurred, on the date stated above, at *1:30 p.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Cancer of face**57*(duration) *5* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

*48*

(duration) ..... yrs. .... mos. .... ds.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *✓*WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *EB Wade*, M. D.Address) *Clever 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

DATE OF BURIAL

*Deshares Cem**Mar. 19 1930*

## 20. UNDERTAKER

ADDRESS

*J. H. Maples**Clever 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.

