

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

Do not use this space.

12473

21. PLACE OF DEATH

County Jackson Registration District No. 395
Township Blue Springs Mo Primary Registration District No. 4232
City Blue Springs Mo (No. _____) St. _____ Ward _____

2. FULL NAME

Edward B. Hallar

(a) Residence. No. _____ St. _____ Ward. Blue Springs Mo
(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 <u>Male</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Hattie D. Hallar</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jun 15 1882</u>		
7. AGE <u>78</u>	YEARS <u>3</u>	MONTHS <u>13</u>
		DAYS <u>13</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Merchant</u> (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Independence Mo</u>		
PARENTS	10. NAME OF FATHER <u>Jacob Hallar</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Fredrickburg Mo</u>	
	12. MAIDEN NAME OF MOTHER <u>Jane Wilkins</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Merriam Mo</u>	
14. INFORMANT <u>Earl C. Hallar</u> (Address) <u>K.C. Mo</u>		
15. FILED <u>5/10 1930</u>		

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28 1930

17. I HEREBY CERTIFY, That I attended deceased from April 22 1930, to Apr 28 1930, that I last saw him alive on April 28 1930, and that death occurred, on the date stated above, at 3:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio sclerosis

132A
97 (duration) yrs. mos. ds.

CONTRIBUTOR (SECONDARY) Nephritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at place of death
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Clinical Hospital
(Signed) F.W. Little M. D.
, 19 (Address) Blue Springs

*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 <u>Mt Washington Cem</u>	DATE OF BURIAL <u>4-30 1930</u>
20. UNDERTAKER <u>G.B. Webb</u>	ADDRESS <u>Blue Springs Mo</u>

Every item of information 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.

May 21 6 1930

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**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 Jackson
Township Sinabon
City (No.) St. Ward

Registration District No. 395-
Primary Registration District No. 4232

File No.
Registered No.
St. Ward

2. FULL NAME Edward C. Haller

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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

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 (Address)

15.

FILED 10 1930 F. W. Pettibone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 28 19 30

17. I HEREBY CERTIFY, That I attended deceased from to 19....., and that I last saw him (duration) yrs. mos. ds. death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

19

20. UNDERTAKER

ADDRESS

WHILE PLACED IN THIS SUPPLEMENTARY RECORD
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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-12472