

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

Do not use this space.

18408

1. PLACE OF DEATH

County Veranda
Township Payson
City Sheldon (No.)

Registration District No. 878
Primary Registration District No. 4531

File No.
Registered No. 13 St. Ward)

2. FULL NAME Leondius Brown Hall

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

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 Maudie M Hall

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1 1

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 10 9

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Columbia
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Frank W Hall

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

12. MAIDEN NAME OF MOTHER Lydna A Wisdom

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

14. INFORMANT Maudie M Hall
(Address)

15. FILED 5/29/30 Carroll T Berry
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1929, to May 27, 1930.
That I last saw him alive on May 27, 1930, and that death occurred, on the date stated above, at 7:40 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Over dose of Chloroform
Hydrate taken accidentally
17 1/2 grs
9 3/4 (duration) yrs. mos. ds. about 5 hours

CONTRIBUTORY (SECONDARY) Myocarditis (chronic)
Heart Thrombosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

Did an operation precede death? no DATE OF 4/1

Was there an autopsy? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Arthur G. Utsumi, M. D

5/29, 1930 (Address) Sheldon 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 Sheldon Mo DATE OF BURIAL 5-29 1930

20. UNDERTAKER J. B. Berry & Sons ADDRESS Sheldon

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.

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100-100000-100000

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

3-30
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Stanton Registration District No. 878 File No.
 Township Primary Registration District No. 4531 Registered No. 13
 City Sheldon (No.) St. Ward

2. FULL NAME Leondius Brown Hall
 (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) 1862-7-18

7. AGE YEARS MONTHS DAYS If LESS than 1 day, of hrs. or min.
67 | 10 | 9

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

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 5-29-30 Cawell T. Berry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1930

17. I HEREBY CERTIFY That I attended deceased from 19....., to 19....., and that I last saw him alive on 19....., and that 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 (duration) yrs. mos. ds.

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

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

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.

SUPPLEMENTARY

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