LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

SEP 26 1933

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 27139

1 PLACE OF DEATH

County New Madrid

Township Como Registration District No. 605 File No.

or

Village Parma-Mo Primary Registration District No. 4359 Registered No.

or

City (NO. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Percy Lee Hall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan (Month) 5 (Day) 1933 (Year)

7 AGE yrs. 7 mos. 24 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Malden-Mo

PARENTS

10 NAME OF FATHER C. L. Hall

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Blackton, Ark.

12 MAIDEN NAME OF MOTHER Lula May Jones

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Alabama

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. L. Hall

(Address) Malden, Mo.

15

Filed 8-30, 1933 Mrs C. S. Blackman

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. (Month) 29 (Day) 1933 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug. 12, 1933, to Aug 28, 1933, that I last saw him alive on Aug. 19, 1933, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Colitis

119

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Malaria

(Duration) yrs. 1 mos. ds.

(Signed) Dr. Jolene Best M. D.

Aug. 29 1933 (Address) Parma-Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Malden Cem. DATE OF BURIAL Aug. 30 1933

20 UNDERTAKER ADDRESS

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE — MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH .....
(Month) (Day) ....., 1..... (Year)

7 AGE .....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h.....alive on ....., 191.....,
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.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS