

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

Do not use this space.

**MAR 21 1936**

6131

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Kan Primary Registration District No. 1007  
 City N.C. Mo. (No. 1101 1/2 East 8th St.) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Samuel D. Hall  
 (a) Residence, No. 1101 1/2 E 8 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 Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-2-1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
84 11 20

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carpenter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-22-1936

22. I HEREBY CERTIFY, That I attended deceased from Sept 5 1935 to Feb 18 1936  
 I last saw him alive on Feb 15 1936. Death is said to have occurred on the date stated above, at 8452  
 The principal cause of death and related causes of importance were as follows:

my daughter - chronic arteriosclerosis - fibrous degeneration - both feet - (chronic) (pneumonia)

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

13. NAME no record

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no record

15. MAIDEN NAME no record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no record

17. INFORMANT Mrs. Elizabeth Hall  
 (ADDRESS) 1101 1/2 East 8th St.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Mt. Moriah DATE Feb 24-36

19. UNDERTAKER Wm. E. Forster  
 (ADDRESS) 723 1/2 N. M. Crome

20. FILED 723 1/2 N. M. Crome  
 Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Edwin C. White M. D.  
 (Address) 1032 Park

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.

Professional Bldg.

1A-2332

1:00 till 3:00