

35997

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 284

Primary Registration District No. 5409

Registrar's No. 15

1. PLACE OF DEATH: Clarkton Mo.

(a) County Dunklin

(b) City or town Clarkton Mo.

(c) Name of hospital or institution: Faustman Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community most of life  
years, months or days

2. USUAL RESIDENCE OF DECEASED: //

(a) State Mo. (b) County Dunklin

(c) City or town Clarkton  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Wm R. Hall

3. (b) If veteran, name war. ✓

3. (c) Social Security No. ✓

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced. married

6. (b) Name of husband or wife Pearl Hall

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased. March 14 1893  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16<sup>th</sup>  
year 1939 hour 8:30 minute 2 PM M.

21. I hereby certify that I attended the deceased from Aug 14 1938 to Oct 16 1939  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>6</u>	<u>2</u>	hr. _____ min. _____

Immediate cause of death Gastric carcinoma

Due to \_\_\_\_\_

Due to H<sub>2</sub>O

9. Birthplace Tenn. (City, town, or county) Tenn. (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name R. J. Hall

13. Birthplace England (City, town, or county) England (State or foreign country)

14. Maiden name Mary Kay

15. Birthplace alt. (City, town, or county) alt. (State or foreign country)

Other conditions Prostatic Hypertrophy 6 yrs

(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Pearl Hall

(b) Address Clarkton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-39  
(Month) (Day) (Year)

(c) Place: burial St. Paul's Church

18. (a) Signature of funeral director Lester J. ...

(b) Address Camphell Mo.

19. (a) 10-16-39 (Date received local registrar) (b) J. B. Steinhilber (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. B. Steinhilber (M. D. or other) MD

Address Clarkton Mo. Date signed 10-16-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

50M-517-39  
Rev. 5-17-39  
I X1931

RECEIVED

District Health Officer No. 3,

District File Number 1139-628

Date Filed 11/6/39

MAY 27 1949

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STATEMENT, BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**