

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

1 X19511

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.

Registration District No. 233

Primary Registration District No. 3027

Registrar's No. 92

1. PLACE OF DEATH:

(a) County, Macon

(b) City or town, Macon
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution five days
(Specify whether)

In this community all of life
years, months or days

3. (a) PRINT FULL NAME Susie Hall 4072

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife Wm P. Hall

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased June 13 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 4 Days 11
If less than one day hr. _____ min. _____

9. Birthplace Summerville Shelby Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business none

12. Name Morgan Davis

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

14. Maiden name Sarah McQuary

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

16. (a) Informant's own signature W P Hall

(b) Address Atlanta Mo.

17. (a) Atlanta Ga. (b) Date thereof 10-26-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Macon Co. Mo.

18. (a) Signature of funeral director Stephens Gooding

(b) Address Macon Mo.

19. (a) 11/6/39 (b) Geo H Keurtau
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

(c) City or town Nickilton Mo. R.R. out of
(If outside city or town limits, write "RURAL")

(d) Street No. Atlanta Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 24, year 1939 hour 4 minute 50 P.M.

21. I hereby certify that I attended the deceased from Oct-15, 1939, to Oct-24, 1939;

that I last saw him alive on Oct-24, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis

Duration 12 days

Due to _____

Due to _____

Other conditions (?)
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations ✓

Of autopsy ✓

Underline the cause to which death should be charged statistically.

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 A L Casbire (M. D. or other) ✓

Address Macon Mo. Date signed 11-6-39

78

RECEIVED

District Health Officer No. 10

District File Number 11-39-1994

Date Filed NOV 8 1939

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed Ch. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, Ma

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

36614

Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 533
 (b) Township 7 Primary Registration District No. 3027 Registered No. _____
 (c) City Macon (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Susie Hall

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W
 (write the word)

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.
61 4 4

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

FATHER
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 24 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Enterobalitis (Enteric)

Date of onset

Other contributory causes of importance: 78 W

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) A. L. Combs, M. D.

(Address) Macon

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

SUPPLEMENT

