

FILED FEB 9 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH2132
Do not use this space.

1. PLACE OF DEATH

(a) County Cole Registration District No. 213
 (b) Township 0 Primary Registration District No. 3014 Registered No. 7
 (c) Jefferson City, Mo. (d) Street No. St. Mary's Hospital 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 Carrie Hall

(a) Residence, No. 519 Madison 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 Female 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 Major Chas. J. Hall

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 27, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 6 8

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

12. BIRTHPLACE (CITY OR TOWN) Levenworth, Kan. (STATE OR COUNTRY)13. NAME Grant Marsh14. BIRTHPLACE (CITY OR TOWN) Penn. (STATE OR COUNTRY)15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)17. INFORMANT Major J. Hall (ADDRESS) Jefferson City, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peter's DATE 1/8/40 1919. FUNERAL DIRECTOR (NAME) John F. Heinrichs (ADDRESS) Jefferson City, Mo.20. FILED 1/9/40 19 40 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/5/40 19

22. I HEREBY CERTIFY, That I attended deceased from August 1, 1939 to January 5, 1940
 I last saw her alive on January 5, 1940 Death is said to have occurred on the date stated above, at 11:40 p.m.
 The principal cause of death and related causes of importance were as follows:

Hypertensive Heart Disease with Left Bundle Branch heart block Date of onset

Other contributory causes of importance:

Chronic coma 1/4/40

Name of operation ectomy Date of 1/4/40
 What test confirmed diagnosis ectomy Was there an autopsy? No

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? No
 If so, specify _____

(Signed) Judian A. Assmann M. D.
 (Address) Jefferson City, Mo.

95182

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 John F. Hennrichs
Licensed Embalmer No. 3655
P. O. Address Jefferson City, Mo.

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

2132
Do not use this space.

1. PLACE OF DEATH
 (a) County Cole Registration District No. 213
 (b) Township Jefferson Primary Registration District No. 3014 Registered No. _____
 (c) City Jefferson (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 Carrie 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 (write the word) m

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.
	<u>69</u>	<u>6</u>	<u>8</u>	

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) 1-5-40

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:
Hypertensive Heart Disease with left Bundle Branch Heart Block
Myocardial Infarction
 Other contributory causes of importance: _____
 (Signed) Julian Cronan, M. D.
 (Address) Jefferson city mo

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 _____

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

