

STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 13 1940

Registration District No. 266

Primary Registration District No. 5373

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Dent  
(b) City or town Rural Franklin  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: XXXX  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution XXXXXX  
XXX (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah S Halbrooks

3. (b) If veteran, name war XXXX 3. (c) Social Security No. XXX

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife George S Halbrooks 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Sept 30  
(Month) (Day) (Year)

8. AGE: Years 80 Months Days If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business XXXX

MOTHER FATHER { 12. Name William Barksdale

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

14. Maiden name Mary E Daughterty

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

16. (a) Informant's own signature Arthur Halbrooks

(b) Address Salem Mo

17. (a) Burial (b) Date thereof Jan 11 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Halbrooks Cem

18. (a) Signature of funeral director Paul Spence  
(b) Address Salem Mo 240

19. (a) January 10 1940 (b) F. E. Butler, M.D.  
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent  
(c) City or town rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. XXXX  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? ZZZZ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9  
year 1940 hour 8 minute X A. M.

21. I hereby certify that I attended the deceased from Nov 19 1939 to Dec 7 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 5 yrs. Duration

Due to Senility 1930

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none done Of autopsy none made  
PHYSICIAN 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 Lloyd H. Hunt, M.D. (M. D. or other)  
Address Salem, Mo. Date signed 1/10/40

WALLEN PLAINER - 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.

OFFICE OF THE REGISTRAR  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND GENERAL SERVICES

**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, ~~and by~~.....

....., Registered Apprentice No. ....

working under my personal supervision.

District Health Officer No. 5,

District File Number 240-179

Date Filed 2740

Signed Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, Md.

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

2221  
Do not use this space.

1. PLACE OF DEATH

(a) County Dent Registration District No. 266  
 (b) Township Franklin Primary Registration District No. 3373 Registered No. 7  
 (c) City..... (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 Sarah S. Halbrook

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 30 1889

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>80</u>	<u>3</u>	<u>9</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. FUNERAL DIRECTOR (ADDRESS)  
 20. FILED Jan 10 1940 F. E. Butler, M.D. Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-9 1940

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:

Other contributory causes of importance:

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) Lloyd H. Hunt, M. D.  
 (Address) Salem, Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY THE BOARD OF HEALTH. EXACT STATEMENT OF CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION AND TRADE, PROFESSION, OR BUSINESS IN WHICH WORK WAS DONE, AS SAWMILL, BANK, ETC. EXACT STATEMENT OF TRADE, PROFESSION, OR BUSINESS IN WHICH WORK WAS DONE, AS SAWYER, BOOKKEEPER, ETC. EXACT STATEMENT OF DATE DECEASED LAST WORKED AT THIS OCCUPATION (MONTH AND YEAR). EXACT STATEMENT OF DATE OF BIRTH (MONTH, DAY, AND YEAR). EXACT STATEMENT OF SEX, COLOR OR RACE, SINGLE, MARRIED, WIDOWED, OR DIVORCED (WRITE THE WORD). EXACT STATEMENT OF COUNTY, TOWNSHIP, CITY, AND STREET NUMBER (IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, WRITE ITS NAME INSTEAD OF STREET AND NUMBER). EXACT STATEMENT OF LENGTH OF RESIDENCE IN CITY OR TOWN WHERE DEATH OCCURRED. EXACT STATEMENT OF HOW LONG IN U.S., IF OF FOREIGN BIRTH. EXACT STATEMENT OF USUAL PLACE OF ABODE, IF NO STREET ADDRESS, WRITE COUNTY OR CITY. EXACT STATEMENT OF CITY OR TOWN AND STATE, IF NONRESIDENT. EXACT STATEMENT OF MANNER AND NATURE OF INJURY. EXACT STATEMENT OF DATE OF INJURY. EXACT STATEMENT OF WHERE DID INJURY OCCUR. EXACT STATEMENT OF WHETHER INJURY OCCURRED IN INDUSTRY, IN HOME, OR IN PUBLIC PLACE. EXACT STATEMENT OF MANNER OF INJURY. EXACT STATEMENT OF NAME OF OPERATION. EXACT STATEMENT OF DATE OF OPERATION. EXACT STATEMENT OF WHAT TEST CONFIRMED DIAGNOSIS. EXACT STATEMENT OF WHETHER THERE WAS AN AUTOPSY. EXACT STATEMENT OF ACCIDENT, SUICIDE, OR HOMICIDE. EXACT STATEMENT OF DATE OF INJURY. EXACT STATEMENT OF WHERE DID INJURY OCCUR. EXACT STATEMENT OF WHETHER INJURY OCCURRED IN INDUSTRY, IN HOME, OR IN PUBLIC PLACE. EXACT STATEMENT OF MANNER OF INJURY. EXACT STATEMENT OF NATURE OF INJURY. EXACT STATEMENT OF WHETHER DISEASE OR INJURY IN ANY WAY RELATED TO OCCUPATION OF DECEASED. EXACT STATEMENT OF WHETHER SO, SPECIFY. EXACT STATEMENT OF SIGNATURE AND ADDRESS OF REGISTRAR.

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