

FILED MAR 23 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH6225  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Carroll Registration District No. 135  
 (b) Township or City Carrollton Primary Registration District No. 3010 Registered No. 35  
 (c) City Carrollton (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

Wingfield Hale  
 (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 <u>M.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct. 14, 1865</u>		
7. AGE	YEARS <u>74</u>	MONTHS <u>5</u>
	DAYS <u>1</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Retired</u>	
	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) <u>Carrollton Mo.</u>		
FATHER	13. NAME <u>John B. Hale</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
MOTHER	15. MAIDEN NAME <u>Mary Casby</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
17. INFORMANT (ADDRESS) <u>Mrs. Parrie Hale Carrollton Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Oak Hill</u> DATE <u>Mar. 17, 1940</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Standley 131 Carrollton Mo.</u>		
20. FILED <u>3-16</u> 19 <u>40</u> <u>Wuth Haskins</u> Local Registrar		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 15, 1940

22. I HEREBY CERTIFY, That I attended deceased from 3-13-40, 1940 to 3-15, 1940  
 I last saw him alive on 3-15, 1940. Death is said to have occurred on the date stated above, at 6:00 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Pneumonia Bronchial Date of onset  
3-13-40  
Diabetes 54

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) Clayton T. Hale, M. D.  
 (Address) Northbarne, Mo.

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.

RECEIVED FILED STATE OFFICE  
INDEX CARD RETURNED TO DISTRICT  
DATE 31-22-40

**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 Ben W Gibson  
Licensed Embalmer No. 2961  
P. O. Address Carrollton

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6225-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 133

Primary Registration District No. 3010

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. Carroll

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

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

(d) Length of stay: In hospital or institution..... (Specify whether  
in this community..... years, months or days)

3. (a) PRINT FULL NAME Kingfield Hale

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

4. Sex. M 5. Color or race. W 6. (a) Single, widowed, married, divorced. 8

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

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

8. AGE: Years 74 Months 5 Days 1 If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 3-16-40 (b) Quith Haskin  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

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

(d) Street No. 305 N Main St  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 15 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

Duration

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 Eugene Balas (Print name)  
Address Harbourside (Print address)

SUPPLEMENTAL REPORT

