

11-10-39  
1-17-39  
I X21492

Registration District No. **875**

Primary Registration District No. **6162**

Registrar's No. **253**

**1. PLACE OF DEATH:**

(a) County Vernon

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

(c) Name of hospital or institution: State Hosp #3  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days 3  
(Specify whether years, months or days)

In this community unknown

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Greene

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

(d) Street No. 431 W Pine St  
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

8. (a) PRINT FULL NAME Harry Linder Hall

3. (b) If veteran, name war unknown 8. (c) Social Security No. 2022

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

6. (b) Name of husband or wife Meda Burnett Hall 8. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased (Month) 4 (Day) 28 (Year) 1881

8. AGE: Years 59 Months 5 Days 18 If less than one day hr. min.

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

10. Usual occupation NPA laborer

11. Industry or business

12. Name Jessie Franklin Hall

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

14. Maiden name Mary Jane Shivers

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

16. (a) Informant Hosp #3 Record (b) Address Nebraska 200

17. (a) Burial (b) Date thereof 10/17/40 (c) Place: burial or cremation Springfield, Mo

18. (a) Signature of funeral director Wm J. ... (b) Address ... Mo

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 10 day 16 year 1940 7 hour 30 minute A M.

21. I hereby certify that I attended the deceased from 10-2, 1940, to 10-16, 1940 that I last saw him alive on 10-16, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocardial degeneration

Due to hypostatic pneumonia

Other conditions hypostatic pneumonia (Include pregnancy within months of death)

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

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

23. Signature Wm J. ... (M. D. or other) 1740 Address State Hosp #3 Date signed 10-16-40

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

926

RECEIVED

District Health Officer No. 7, -

District File Number 10-40-1023

Date Filed 11-4-40

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

Signed Lloyd Winsett  
Licensed Embalmer No. 2857  
P. O. Address Muada, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36625-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 875-

Primary Registration District No. 6167

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Washington  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Harry Linden Hall

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 m

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 59 Months 5- Days 18 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (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.

20. DATE OF DEATH: Month 10 day 16  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Chr. sup. Carditis  
degeneration

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

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

Other conditions: hypostatic pneumonia  
(include pregnancy within 6 months of death)

Major findings: Bronchial type tuberculosis  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline 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)

23. Signature J. J. [unclear] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 12/16/40

SUPPLEMENTARY

