

FILED JAN - 8 1943

Registration District No. **7**

Primary Registration District No. **3072 3023**

Registrar's No. **124**

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

1. PLACE OF DEATH:
 (a) County **Johnson**
 (b) City or town **Warrensburg**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
417 W. Gay St. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **44 yrs.** years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Johnson**
 (c) City or town **Warrensburg**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **417 W. Gay St.**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Oscar Blin Hall**
 (b) If veteran, name war **none**
 (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **2** year **1942** hour **12:15** minute **A.M.**
21. I hereby certify that I attended the deceased from **June** 19**42** to **12-1** 19**42**
 that I last saw him alive on **12-1** 19**42** and that death occurred on the date and hour stated above.

4. Sex **Male** **5. Color or** **Caucasian**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Gephia E. Hall**
6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **Dec - 28** 18**68**
 (Month) (Day) (Year)

Immediate cause of death **Cerebral arteriosclerosis**
 Duration **2 yrs.**
 Due to _____
 Due to _____
 Other conditions **Cholelithiasis**
 (Include pregnancy within 3 months of death)

8. AGE: Years **73** Months **11** Days **4** If less than one day _____ hr. _____ min.
9. Birthplace **Kent Co. Michigan**
 (City, town, or county) (State or foreign country)
10. Usual occupation **Physician**

PHYSICIAN
 Major findings:
 Of operations **Arteriosclerosis**
 Of autopsy **Cholelithiasis**
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____
12. Name **Seth Thompson Hall**
13. Birthplace **Middleburg N. York**
 (City, town, or county) (State or foreign country)
14. Maiden name **Margaret Ann Phillips**
15. Birthplace **Grand Rapids Mich.**
 (City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. O. B. Hall**
(b) Address **Warrensburg, Mo.**
17. (a) Burial (Burial, cremation, or removal) **Dec. 3 - 1942** (Month) (Day) (Year)
(c) Place: burial or cremation **Sunset Hill**
18. (a) Signature of funeral director **Dworney-Phillips**
(b) Address **Warrensburg, Mo.**
19. (a) Dec. 3, 1942 (Data received local registrar) **(b) Leola M. Williams** (Registrar's signature)

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) _____
 Means of injury _____
23. Signature **Philip Cooper** (M. D. or other) _____
Address **Warrensburg, Mo.** **Date signed** **12-3-42**

- 1001

JUN 20 1947

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-7-43

JAN 15 1951

DEC 12 1951

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 R. A. Phillips

Licensed Embalmer No. 2320

P. O. Address... Warrensburg!

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, fact should be so stated above.