

No. 2  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13199

State File No. \_\_\_\_\_

FILED MAY 6 1943

Primary Registration District No. 1002

Registrar's No. 1931

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

1. PLACE OF DEATH:

(a) County JACKSON

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

(c) Name of hospital or institution:  
ST. MARY'S  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 42 days  
(Specify whether years, months or days)

In this community 42 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM PATRICK HALL

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex MALE 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased MAY 22, 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>11</u>	<u>0</u>	hr. _____ min

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

10. Usual occupation Retired Mail Employee

11. Industry or business Rail Road

MOTHER FATHER

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant Hospital Record

(b) Address St. Mary's Hospital

17. (a) Atchison, Mo. (b) Date thereof 4.22.43  
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Haxton, Kansas

18. (a) Signature of funeral director Augustus

(b) Address Atchison, Kansas

19. (a) 4.22.43 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 48

(c) City or town Blue Springs 0  
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22  
year 1943 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from March 11, 1943, to April 22, 1943;  
that I last saw him alive on April 21, 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death lung abscess with (non tuberculous) right emphysema

Due to arterio-sclerotic gangrene left foot 7 who

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

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

Major findings: arterio-sclerotic gangrene left foot

Of operations \_\_\_\_\_

Of autopsy see - "Cause of death"

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 J. E. Castle (M. D. certifier)

Address 1002 Ogden Bldg Date signed 4.22.43

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(Licensed Embalmer's Statement on Reverse Side)

Kb. Two

**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.....

*George E Harouff*

Registered Apprentice No.....

working under my personal supervision.

Signed.....

*George E Harouff*

Licensed Embalmer No.....

*820*

P. O. Address.....

*Johnson Ave*

**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.**