

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13623

State File No. _____

FILED MAY 10 1940

Registration District No. 3/140

Primary Registration District No. 4040

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Benton

(b) City or town Cole Camp
(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 (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Benton

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Robert Hault

3. (b) If veteran, name war _____

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mrs. Orfa Hault

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased November 10th 1874
(Month) (Day) (Year)

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

68 4 3 _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Henry Hault

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

14. Maiden name Unknown

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

16. (a) Informant S. A. Hault

(b) Address 1301 Armour Kansas City, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17, 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Cole Camp Cemetery

18. (a) Signature of funeral director E. L. Bickhoff

(b) Address Cole Camp Mo

19. (a) April-16-43 (Date received local registrar) (b) Pauline Harms (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13 year 1943 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from never to never that I last saw him alive on 4-12-1943 and that death occurred on the date and hour stated above.

Immediate cause of death Heart (Apparently)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 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? _____ (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)

(c) Means of injury _____

23. Signature Lee Hult (Carones) (M.D. or other) _____

Address Cole Camp Mo Date signed 4-13-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1347 (Licensed Embalmer's Statement on Reverse Side)

District No. 7
District File Number 4-43-222
Date Filled 5-7-43

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 E. L. Eickhoff

Licensed Embalmer No. 736

P. O. Address Cole Camp 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13623
Registrar's No. 13

Registration District No. 31

Primary Registration District No. 4040

1. PLACE OF DEATH:

(a) County Benton
(b) City or town Cole Camp
(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 years, months or days)

3. (a) PRINT FULL NAME Robert Hunt

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 Wife 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Nov 10 - 1874
(Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days - (If less than one day, min.)

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

10. Usual occupation

11. Industry of 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Benton
(c) City or town Cole Camp
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1943 hour 11 minute 30 M.

21. I hereby certify that I attended the deceased from 11/10/43 to 11/12/43 that I last saw him alive on 11/12/43 and that death occurred on the date and hour stated above. Immediate cause of death Heart

Due to Chronic Myocarditis
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93d

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? (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 See Hunt (Carover) (M. D. or other) MD
Address by Dr. Reser MD Date signed

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

