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LED MAY 10 1943

Registration District No. **642**

Primary Registration District No. **5851**

Registrar's No. **9**

1. PLACE OF DEATH:  
(a) County **Oregon**  
(b) City or town **Rural Washington imp**  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MO** (b) County **Oregon**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL.")  
(d) Street No. **Frederick St MO**  
(If rural, give location)  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Andrew Haller**  
3. (b) If veteran, name war  3. (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **April** day **7** year **1943** hour **11 A** minute **4** M.  
21. I hereby certify that I attended the deceased from **Jan 21** 19**43** to **April 7** 19**43**  
that I last saw him alive on **April 6** 19**43** and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color **White** 6. (a) Single, widowed, married, divorced, **Widowed**  
6. (b) Name of husband or wife **Catherine Hall (deceased)** 6. (c) Age of husband or wife if alive **85 1/2** years  
7. Birth date of deceased: **Nov 30 1857**  
(Month) (Day) (Year)

Immediate cause of death **Pneumonia lobar** Duration **5 days**

8. AGE: Years **85** Months **7** Days **26** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to **Senile Debility**

9. Birthplace **Rich Farmain MO**  
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Retired Farmer**

Other conditions. (Include pregnancy within 3 months of death) **108**

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name **Don't know**  
13. Birthplace **Germany** (State or foreign country) **4**  
14. Maiden name **Don't know**  
15. Birthplace **Germany** (State or foreign country) **4**

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

16. (a) Informant **Frank Haller**  
(b) Address **Frederick MO**  
17. (a) **Burial** (b) Date thereof **April 9 1943**  
(c) Place: burial or cremation **Frederick MO**

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? \_\_\_\_\_

18. (a) Signature of funeral director **Ma Hall**  
(b) Address **Frederick MO**  
19. (a) **418-43** (b) **Antonia Kluba**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
23. Signature **Frank A. Waughler** (M. D. or other) **0**  
Address **Frederick MO** Date signed \_\_\_\_\_

1294

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

P

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**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

*H. H. Strop*

Licensed Embalmer No.

*2924*

P. O. Address

*Meta 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. \_\_\_\_\_

Registration District No. (260)

Primary Registration District No. (5889)

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Osage  
(b) City or town Rural 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

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Andrew Heller

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 W

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

7. Birth date of deceased Nov. 30 1900  
(Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days 20 min. \_\_\_\_\_  
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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director W. H. Strope

(b) Address Weta, Mo

19. (a) 4-8-43 (b) Andrew Heller  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 30 Year 1943 Minute \_\_\_\_\_ M. 7

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; 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 \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

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

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

S-15043