

Registration District No. **77**

Primary Registration District No. **3016**

Registrar's No. **137**

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

1. PLACE OF DEATH: **Cole**  
 (a) County **Jefferson City MO**  
 (b) City or town **Jefferson City MO**  
 (c) Name of hospital or institution **Jefferson Heights apts. 1**  
 (d) Length of stay: In hospital or institution **2 mo**  
 In this community **2 mo**

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **MO** (b) County **Cole**  
 (c) City or town **Jefferson City MO**  
 (d) Street No. **Jefferson Heights apt**  
 (e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Mrs Leon M Hall**  
 (b) If veteran, name war   
 (c) Social Security No.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **July** day **19**  
 year **1949** hour **3:15** minute **19** M.  
 21. I hereby certify that I attended the deceased from **no attendance**  
 that I last saw h. alive on **no attendance**  
 and that death occurred on the date and hour stated above.

4. Sex **F** 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **married**  
 (b) Name of husband or wife **Leon M. Hall**  
 (c) Age of husband or wife if alive **47** years  
 7. Birth date of deceased **Sept 29 1895**

Immediate cause of death  
**Cerebral Hem**  
**apoplexy**  
**Hypertension**  
 Other conditions (Include pregnancy within 3 months of death) **None**

8. AGE: Years **47** Months **9** Days **2**  
 9. Birthplace **Greenfield MO**  
 10. Usual occupation **Housewife**

Major findings: **None**  
 Of operations **None**  
 Of autopsy **None**

MOTHER FATHER {  
 12. Name **Robert M Sloan**  
 13. Birthplace **Greenfield MO**  
 14. Maiden name **Melba Sloan**  
 15. Birthplace **Greenfield MO**

16. (a) Informant **Mr Leon M Hall**  
 (b) Address **Jefferson Heights apt Jefferson City MO**  
 17. (a) **Burial** (b) Date thereof **July 3 43**  
 (c) Place: burial or cremation **Greenfield MO**  
 18. (a) Signature of funeral director **John J Gordon**  
 (b) Address **217 E. McCarty Des Moines MO**  
 19. (a) **7-2-43** (b) **Miriam Bichter**

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 **Edw M ...** (M.D. or other) \_\_\_\_\_  
 Address **Jefferson City MO** Date signed **7-7-49**

1981

**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 *Louis J. [Signature]*

Licensed Embalmer No. *4096*

P. O. Address *[Signature]*

**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.**

Registration District No. 17

Primary Registration District No. 3016

Registrar's No. 137

1. PLACE OF DEATH:

(a) County Cole  
 (b) City or town Jefferson city  
(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 2 mo (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs Neva Hall  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex ♀ 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 Sept 29  
(Month) (Day) (Year)

8. AGE: Years 47 Months 9 Days m  
(Unless less than one day, min.)

9. Birthplace Mo  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Green  
 (c) City or town Greenfield Mo  
(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 \_\_\_\_\_  
 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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 \_\_\_\_\_

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

SUPPLEMENTARY

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

3.

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