

No. 2  
9-11  
17-35  
X22484

FD JUL 26 1943  
Registration District No. 152A

Primary Registration District No. 152A

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter, Mo. R. 3.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Liberty camp  
(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: 103

(a) State Missouri (b) County Stoddard 0

(c) City or town Dexter, R. 3. 0  
(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 \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Wylie M. Halfacre

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 13  
year 1943 hour 6 minute 30 P.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Cora Halfacre 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased: Jan. 28, 1859  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 12, 1943 to June 12, 1943  
that I last saw him alive on June 10, 1943, 1943  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>4</u>	<u>16</u>	hr. _____ min.

Immediate cause of death Acute Nephritis

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

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER {

12. Name Jacob Halfacre

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

14. Maiden name Margaret Roland

15. Birthplace New York City, N.Y.  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Cora Halfacre

(b) Address Dexter, Mo. R. 3.

17. (a) Burial (b) Date thereof June 15, 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dexter

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature A. J. Cannon (M.D. or other) AD

Address Dexter Date signed 6/15/43

18. (a) Signature of funeral director Watkins Funeral Ser.

(b) Address Dexter, Mo.

19. (a) July 4, 1943 (b) Mora Smith  
(Date received local registrar) (Registrar's signature)

134

RECEIVED

District Health Office No. 2,

District File Number 743-944

Date Filed 7-23-43

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 Nantz Abhill

Licensed Embalmer No. 4210

P. O. Address Silvest

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. 341

Primary Registration District No. 6102A

Registrar's No. 27

1. PLACE OF DEATH:  
(a) County Stoddard  
(b) City or town Rural Liberty Jimp  
(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 \_\_\_\_\_)  
3. (a) PRINT FULL NAME Wylie M. Halfon  
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 \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Jan 28 1910  
(Month) (Day) (Year)

8. AGE: Years 84 Months 02 Days 02 (Unless than one day, min.)

9. Birthplace \_\_\_\_\_ (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 \_\_\_\_\_ (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 \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 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 Acute hyperacute Chronic Interstitial Nephritis

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) 131a

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 H. Cannon (M. D. or other) \_\_\_\_\_  
Address Center Date signed 8/2/43

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

SUPPLEMENTARY

S-26318

5 200X