

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Conley Clinical Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Nine days**
(Specify whether
In this community **2 yrs.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **634 Garfield**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Carl Williamson Halgran**

3. (b) If veteran, name war **WW** 3. (c) Social Security No. **293098972**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Unknown**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **April 15, 1890**
(Month) (Day) (Year)

8. AGE: Years **53** Months **5** Days **24** If less than one day
hr. min.

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

10. Usual occupation **Lens Grinder (Optical)**

11. Industry or business **Optical Industry**

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **C. S. Anderson**

(b) Address **Kansas City, Mo.**

17. (a) **Burial** (b) Date thereof **Oct. 14 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. St. Marys Missouri**

18. (a) Signature of funeral director **Passantino Bros**

(b) Address **Kansas City, Missouri**

19. (a) **10-13-43** (b) **D. E. Brown**
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **9**
year **1943** hour **10** minute **43 A.M.**

21. I hereby certify that I attended the deceased from **9-30-43**
19 **10-9** to **10-9** 19 **43**
that I last saw him alive on **10-9** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Asymptotic pneumonia**

Due to **Acute Gastritis**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

18 hrs

10 days

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) (a) Means of injury.....

23. Signature **D. E. Brown** (M. D. or other) **10-10-43**
Address **509 S. 10th St. Kansas City, Mo.** Date signed **10-10-43**

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

FILED NOV 1 1943

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.....

Park G. Rowe

Licensed Embalmer No.

2347

P. O. Address.....

12 C 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 83803
7103

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jennas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Conley Chemical Hoop
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 da (Specify whether
In this community 2 yr years, months or days)

3. (a) PRINT FULL NAME Carl W. Halgion

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 unk.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased april 15 (Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days unk. (If less 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 Oct Day _____ Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to hypostatic pneumonia 48 hr.
acute gastritis 10 da.

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 [Signature] (M. D. or other) _____
Address [Address] Date signed 5-14

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

