No. 2
9-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33025

State File No. .....

FILED NOV 26 1943

Registration District No. .....

Primary Registration District No. 4134

Registrar's No. 95

1. PLACE OF DEATH:

(a) County: CLAY

(b) City or town: SMITHVILLE, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: HOME
(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)
In this community: LIFETIME

2. USUAL RESIDENCE OF DECEASED: 24

(a) State: MO. (b) County: CLAY

(c) City or town: SMITHVILLE 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country: 0

3. (a) PRINT FULL NAME: MARION HUTCHISON HALL

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: MALE

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: SINGLE

6. (b) Name of husband or wife .....

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

7. Birth date of deceased: SEPT. (Month) 19, (Day) 1859 (Year)

8. AGE: Years 84 Months 1 Days 29 If less than one day ..... hr. ..... min.

9. Birthplace: CLAY COUNTY, (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation: FARMER, STOCK BREEDER

11. Industry or business .....

MOTHER FATHER

12. Name: WILLIAM HALL

13. Birthplace: (City, town, or county) KY. / (State or foreign country)

MOTHER

14. Maiden name: SALLY RAVENSCRAFT

15. Birthplace: (City, town, or county) KY. / (State or foreign country)

16. (a) Informant: MRS. ALBERT REED

(b) Address: SMITHVILLE, MO. R.F.D

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 11/20/'43 (Month) (Day) (Year)

(c) Place: burial or cremation: SMITHVILLE, MO.

18. (a) Signature of funeral director: McCowan Funeral Home

(b) Address: Smithville, Mo.

19. (a) Nov 21-1943 (Date received local registrar) (b) Ruth N. Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 18 year 1943 hour 8:30 minute a. M.

21. I hereby certify that I attended the deceased from Nov 1st, 1943, to Nov. 18, 1943, that I last saw h. alive on Nov 18, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia Poisoning with nephritis

Due to: prostatic insufficiency & shock & senility

Due to: .....

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

Major findings:
Of operations: .....
Of autopsy: .....

Duration /

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? .....
(Specify type of place)

While at work? ..... (e) Means of injury 2

23. Signature: Dr R. E. Seth (M. D. or other) D.O.

Address: Smithville Mo. Date signed 11/20/43

1021 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
... Health Officer No. 8
... File Number
Date Filed 11-24-43

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 S. A. McComas,

Licensed Embalmer No. 2303

P. O. Address Smithville, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-5-43
X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 95

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

1. PLACE OF DEATH:
(a) County Clay (b) City or town Smithville
(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) In this community

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 Marion Hutchison Hall
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 14 (Month) (Day) (Year)
8. AGE: Years 84 Months 1 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 18 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Nephritis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

131

38025