S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29389

FILED SEP 30 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8013

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Louis Childrens Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hrs (Specify whether)

In this community 4 hrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford

(c) City or town Cuba
(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 /

28 / 1 / N.R. 0

3. (a) PRINT FULL NAME Virginia Mae Hall

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

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 3 (Month) 12 (Day) 1933 (Year)

8. AGE: Years 11 Months 6 Days 4 If less than one day hr. min.

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

10. Usual occupation Student

11. Industry or business ~~John Randolph Hall~~

FATHER
12. Name John Randolph Hall
13. Birthplace (City, town, or county) West Virginia (State or foreign country)

MOTHER
14. Maiden name Louise Lingreen
15. Birthplace Cuba (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs Ralph Wirz
(b) Address Cuba Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-44 (Month) (Day) (Year)
(c) Place: burial or cremation Cuba Mo

18. (a) Signature of funeral director Hollow Funeral Home
(b) Address Cuba Mo

19. (a) SEP 19 1944 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16th year 1944 hour 4 minute 15 A.M.

21. I hereby certify that I attended the deceased from 9-16, 1944 to 9-16, 1944 that I last saw her alive on 9-16, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial Hemorrhage Rheumatic Heart Disease

Due to Emboli to Brain

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Left temporal Hemorrage of Brain Rheumatic Heart with mitral Valvulitis

Duration: 2 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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Gilbert B. Forbes (M. D. or other)

Address 500 S. Kingshighway Date signed

(Licensed Embalmer's Statement on Reverse Side)

8013

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 Howard R Rowland

Licensed Embalmer No. 3114

P. O. Address Ottawa, Ks

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.