

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

FILED JAN 13 1945

State File No. 46239

Registration District No. 22

Primary Registration District No. 5779

Registrar's No. 59

1. PLACE OF DEATH:

(a) County MILLER

(b) City or town RURAL - FRANKLIN - LAKESIDE  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1  
(Specify whether years, months or days)

In this community 15 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MILLER

(c) City or town RURAL - Franklin  
(If outside city or town limits, write "RURAL")

(d) Street No. LAKESIDE - Mo  
(If rural, give location)

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

If yes, name country None

3. (a) PRINT FULL NAME CHARLES BENJAMIN HALL

3. (b) If veteran, name war none

3. (c) Social Security No. None

4. Sex MALE

5. Color or race White

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

6. (b) Name of husband or wife MORA - HALL

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased APRIL 26 1869  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 3 year 1944 hour 8 minute 45 P M.

21. I hereby certify that I attended the deceased from MARCH - 1934 to Nov 23 1944

that I last saw him alive on Nov 23 1944 and that death occurred on the date and hour stated above.

Immediate cause of death UREMIA

Duration 7 days

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>7</u>	<u>7</u>	<u>-</u> hr. <u>-</u> min.

9. Birthplace WASHINGTON Co ARK.  
(City, town, or county) (State or foreign country)

10. Usual occupation CARPENTER

11. Industry or business BALDING

12. Name JAMES - HALL

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

14. Maiden name MARY (unknown)

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

16. (a) Informant Nancy Hall

(b) Address Lakeside Mo

17. (a) BURIAL (b) Date thereof 12-6-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation White Cem - Houston Mo

18. (a) Signature of funeral director Edon

(b) Address Edon Mo

19. (a) 12-4-44 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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

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

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

Major findings: PHYSICIAN  
Of operations SUPPLEMENTARY INFORMATION REQUESTED

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

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 None

23. Signature E. B. Shelton (M. D. or other MD)  
Address Edon Mo Date signed 12-4-44

RECEIVED

Miller County Health Dep't.

County File Number

45-4

Date Filed

1-2-45

JAN 16 1945

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

*Faith M. Sage*

Licensed Embalmer No.

3998

P. O. Address

Eldon 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.

2B  
43  
K36930

State File No. Jan 6 2  
Registrar's No. 62

Registration District No. 222 Primary Registration District No. 5729

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Rural - Franklin  
(If outside city or town limits, write "RURAL" and name of town)

(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)

3. (a) PRINT FULL NAME Charles B. 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 M

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

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

7. Birth date of deceased April 2  
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days \_\_\_\_\_ (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 \_\_\_\_\_  
(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 \_\_\_\_\_ (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 Dec Year 1946 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 Chronic nephritis

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

Other conditions (Include pregnancy within 3 months of death) 1316

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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? \_\_\_\_\_

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

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

23. Signature E. C. Shelton (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER, FATHER

S-41639

1944