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5-42
17-39
X32673

FILED FEB 14 1945

Registration District No. *14*

Primary Registration District No. *5122*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Boone**
(b) City or town **Hallsville** *North Fork River*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rural Route
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **59 Years** / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone** *10*
(c) City or town **Hallsville** *10*
(If outside city or town limits, write "RURAL")
(d) Street No. **Rural Route** (If rural, give location)
(e) Citizen of foreign country? **No** *10* (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **BEN T. ZARING**

3. (b) If veteran, name war **None** 3. (c) Social Security No. _____

4. Sex **Male** *10* 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

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

7. Birth date of deceased **2 - 16 - 1885**
(Month) (Day) (Year)

8. AGE: Years **59** Months **11** Days **20** If less than one day hr. _____ min. _____

9. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Robert Walter Zaring**

13. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mattie Belle Mount**

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

16. (a) Informant **Mrs. Ben T. Zaring**

(b) Address **Rural Route, Hallsville, Mo.**

17. (a) **Burial** (b) Date thereof **2-8-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hickory Grove Cemetery**

18. (a) Signature of funeral director **Parker Funeral Service**
(b) Address **Columbia, Mo.**

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **6**
year **1945** hour **11** minute **30** A.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 **Gun Shot Wound** Duration _____

Due to **Self Inflicted**

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) **Suicide**

(b) Date of occurrence **Feb. 6, 1945**

(c) Where did injury occur? **Hallsville, Boone, Missouri**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
At Home

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature **D. Ward** *3* **Coroner**
Address **Columbia, Mo.** Date signed **2-7-45**

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

MOTHER FATHER

1243

FEB 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 Chas L. Zarin

Licensed Embalmer No. 41321

P. O. Address Columbia,

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. FebRegistration District No. 40Primary Registration District No. 5122

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Boone
 (b) City or town Hallsville, R.D. #1
 (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 59 years
 years, months or days

3. (a) PRINT FULL NAME Ben J. Zaring

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Erin Zaring 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 16
 (Month) (Day) (Year)

8. AGE: Years 59 Months 11 Days 2 If less than one day, hr. _____ min. _____

9. Birthplace Boone County, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Starkert

11. Industry or business _____

- MOTHER FATHER
 12. Name Robert Walter Zaring
 13. Birthplace Boone Co. Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Mattie Belle Mount
 15. Birthplace Kentucky
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ben T. Zaring
 (b) Address R.R. Hallsville, Mo
 17. (a) Burial (b) Date thereof 2-8-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Hedgery Grove Cem.
 18. (a) Signature of funeral director Arker Funeral Serv

- (b) Address Columbia, Mo

19. (a) Feb 7 (b) Ruby West
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Boone
 (c) City or town Hallsville
 (If outside city or town limits, write "RURAL")
 (d) Street No. Rural Route 1
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15 year 1945 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 _____

Due to _____

Due to _____

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.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

1679