V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 19 1945

Registration District No. 959

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8609

Primary Registration District No. 1002

Registrar's No. 959

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: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week 1 day (Specify whether
In this community 8 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Brunswick
(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 NELLIE HALLIBURTON

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 Widowed

6. (b) Name of husband or wife L.H.Halliburton

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

7. Birth date of deceased 1 (Month) 11 (Day) 1882 (Year)

8. AGE: Years 63 | Months 1 | Days 16 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Housewife

11. Industry or business Self

FATHER
12. Name George W. Porter
13. Birthplace (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Catherine Henry
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Record Desk - Research Hospital
(b) Address Kansas City, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation Brunswick Missouri

18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address 918-920 Brooklyn K.C.Mo

19. (a) 2-28-45 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 27 year 1945 hour 11: minute P. M.

21. I hereby certify that I attended the deceased from Dec 4, 1944 to Feb. 27, 1945 that I last saw her alive on Feb 27, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Coronary Thrombosis	2 days
Due to Arteriosclerosis Arterial Hypertension	
Due to Diabetes Mellitus Pneumococcic Pneumonia	12 days
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations None 61

Of autopsy Same as above

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 Carl R. Ferris (M.D. or other)

Address 934 Argyle Bldg Kansas City, Mo Date signed Feb 28, 1945

(Licensed Embalmer's Statement on Reverse Side)

Dr. C. M.
Argyle Bldg
Mc 8227
Meet Dr. at Research Work
10 P.M.

SEP 3 1946

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 C. H. Nise

Licensed Embalmer No. 2570

P. O. Address K C. Mo

MAY 2 1945

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.