

U.S. No. 2
FORM-2-43
Rev. 5-17-39
X35697

State File No. _____

FILED MAR 20 1945
Registration District No. 1845

Primary Registration District No. 3006

Registrar's No. 45

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42
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Boscawen

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

(c) Name of hospital or institution: University Hospitals D
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)

In this community 4 days

3. (a) PRINT FULL NAME LARRY HALIBURTON

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 Single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased July - 21 - 1941
(Month) (Day) (Year)

8. AGE: Years 3 Months 7 Days 3
If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Joe Haliburton

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

14. Maiden name Maude Ferron

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

16. (a) Informant Joe Haliburton

(b) Address 309 N. Buchanan Moberly MO

17. (a) Removed (b) Date thereof Feb - 24 - 45
(Maid, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly MO

18. (a) Signature of funeral director Snow Funeral Home

(b) Address Moberly MO.

19. (a) 2-24-45 (b) Edna H. Barber
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

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

(d) Street No. 309 N. Buchanan
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24
year 1945 hour 3:30 p.m. M.

21. I hereby certify that I attended the deceased from Feb 20, 1945, to Feb 24, 1945; that I last saw him alive on 2-24, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death

Tuberculosis meningitis

Due to Generalized tubercula

Due to Tuberculosis of upper lobe near base

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

Major findings: Of operations 138

Of autopsy above findings

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 [Signature] (M. D. or other) _____
Address 20 Exchange Bldg Date signed 2-24-45

1250

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 3-19-45

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..... *R. M. Carter*

Licensed Embalmer No. 4117

P. O. Address Marion, 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.