

FILED APR 25 1945
Registration District No. 273

Primary Registration District No. 4436

Registrar's No. 108

1. PLACE OF DEATH

(a) County Ball
(b) City or town NEW LONDON Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution NEW LONDON
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MARIAN 87
(c) City or town NEW LONDON
(If outside city or town limits, write "RURAL") 1
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME William Haley
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 17th
year 1945 hour ABOUT 5:00 minute _____ P. M. P. M.
21. I hereby certify that I attended the deceased from NO
MEDICAL ATTENTION to _____ to _____, 19____;

4. Sex Male 5. Color or race White 6. (a) Single, widowed married, divorced Widowed
6. (b) Name of husband or wife ELLA BELL 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH ? 1961
(Month) (Day) (Year)

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death Myocarditis Duration _____

8. AGE: Years 83 Months 11 Days 14 If less than one day hr. _____ min. _____

Due to Senility
Due to _____

9. Birthplace NEW LONDON MISSOURI
(City, town, or county) (State or foreign country)

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation _____
11. Industry or business _____
12. Name Thomas Haley
13. Birthplace IRLAND
(City, town, or county) (State or foreign country)
14. Maiden name KATHERINE
15. Birthplace _____
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) NO
(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 2

16. (a) Informant Mr FRANK HALL
(b) Address NEW LONDON MO
17. (a) BURIAL (b) Date thereof 2, 20-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation BARKLEY CEMETARY
18. (a) Signature of funeral director James O'Connell
(b) Address Hannibal Mo.
19. (a) 2-20-45 (b) R. S. Becking
(Date received local registrar) (Registrar's signature)

23. Signature Clyde W. ...
Address Ferry, Mo. Date signed 3/1/45

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Michael J. Donnell

Licensed Embalmer No. 3246

P. O. Address Hannibal 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7m 44

Registration District No. 293

Primary Registration District No. 4406

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Rall

(b) City or town New London
(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 _____ years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME William Haley

3. (b) If veteran, name war _____

3. (c) Social Security No. 8

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased mar 3
(Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days no
If less than one day _____ min.

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

10. Usual occupation Farmer Retired

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) R. B. Berkley
(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 Feb Day _____
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)

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) _____

(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 _____

SUPPLEMENTARY

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

MOTHER FATHER

14337