

S. No. 2
M-8-43
v. 5-17-39
X37023

17462

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 204

Primary Registration District No. 5738

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Rural, Lallata Township
(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 6.3 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Cora May Hall

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25, year 1945 hour 11 minute 30. P. M.

21. I hereby certify that I attended the deceased from May 8, 1945 to May 25, 1945 -

that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Chas. H. Hall 6. (c) Age of husband or wife if alive 69 years (Day) (Year)

7. Birth date of deceased: July 23 1880
(Month) (Day) (Year)

Immediate cause of death Uremia
Chronic Interstitial Nephritis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

8. AGE: Years 64 Months 10 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Macon Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

PHYSICIAN

Underline the cause to which death should be charged statistically.

12/12

11. Industry or business _____

12. Name Geo. W. Sinclair

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

14. Maiden name Adora Phillips

15. Birthplace Mo (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) _____

(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 0

23. Signature C. H. Buckley (M. D. or other) _____
Address La Plata Mo. Date signed 5-26-45

16. (a) Informant Chas. Marshall

(b) Address 409 W. 24th St. Kansas City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-45 (Month) (Day) (Year)

(c) Place: burial or cremation Lallata

18. (a) Signature of funeral director D. A. Christie

(b) Address Lallata Mo

19. (a) 5/25/45 (Date received local registrar) (b) H. Mrs. Ross (Registrar's signature)

1590

(Licensed Embalmer's Statement on Reverse Side)

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

1
0
0

RECEIVED

District Health Officer No. 10

District File Number 6-45-992

Date Filed JUN 12 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

D. S. Christie

Licensed Embalmer No.

1109

P. O. Address

La Plata 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.