

S. No. 2  
M-5-43  
v. 5-17-39  
I X36671

17785

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 124

FILED JUN 7 1945  
Registration District No. 274

Primary Registration District No. 3052

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

1. PLACE OF DEATH:  
(a) County PETTIS  
(b) City or town SEDALIA  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: BOTHWELL HOSPITAL 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 HOURS  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County PETTIS 80  
(c) City or town SEDALIA 1  
(If outside city or town limits, write "RURAL") 4  
(d) Street No. 1509 E. 13TH  
(If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CLARENCE JOE HALL  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month MAY day 25TH  
year 1945 hour 11 minute 15 P.M.  
21. I hereby certify that I attended the deceased from 5-25 - 1945 to 5-25 - 1945  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

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 5 - 25 - 1945  
(Month) (Day) (Year)

Immediate cause of death Aplhysia Neonatorum  
Due to atelectasis  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 6 hrs min.  
9. Birthplace SEDALIA Mo. 11  
(City, town, or county) (State or foreign country)  
10. Usual occupation INFANT  
11. Industry or business \_\_\_\_\_  
12. Name CLYDE R. HALL  
13. Birthplace SEDALIA Mo. 0  
(City, town, or county) (State or foreign country)  
14. Maiden name BEATRICE E. SMITH  
15. Birthplace SEDALIA Mo. 11  
(City, town, or county) (State or foreign country)  
16. (a) Informant CLYDE R. HALL  
(b) Address SEDALIA, Mo.  
17. (a) BURIAL (b) Date thereof 5-26-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CROWN HILL CEMETERY  
18. (a) Signature of funeral director Gillaspie  
(b) Address SEDALIA, Mo.  
19. (a) 5/26/45 (b) Mrs Anna Berger  
(Date received local registrar) (Registrar's signature)

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 J. M. Radiman (M. D. or other) M.D.  
Address Sedalia, Mo. Date signed 5-26-45

RECEIVED

District Health Officer No. 8

District File Number

Date Filed

6/6/11

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

Licensed Embalmer No.

P. O. Address

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.