S. No. 2
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X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25718

FILED SEP 14 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7854

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Macoupin 999

(c) City or town Shipman
(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 DAVID HALLIDAY

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mary E. Halliday

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

7. Birth date of deceased January (Month) 1 (Day) 1876 (Year)

8. AGE: Years 69 Months 8 Days 4 If less than one day hr. min.

9. Birthplace Brighton Township (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Andrew Halliday

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

MOTHER 14. Maiden name Elizabeth Perry

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

16. (a) Informant Marshall Halliday

(b) Address Shipman, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-6-45 (Month) (Day) (Year)

(c) Place: burial or cremation Shipman, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 7 1945 (Date received local registrar) (b) J. Medel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 5 year 1945 hour 2 minute 40 P.M.

21. I hereby certify that I attended the deceased from AUG. 27, 1945 to SEPT. 5, 1945 that I last saw him alive on SEPT. 5, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death CONGESTIVE HEART FAILURE — Duration

Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

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 H. Bradley (M. D. or other)

Address Barnes Hospital, Date signed 9/6/45

(Licensed Embalmer's Statement on Reverse Side)

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.