

No. 2
8-43
7-39
X37823

FILED FEB 19 1946

Primary Registration District No. **5325**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County **Crawford**
(b) City or town **Rural (COURTOISE) Twp**
(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 years, months or days)
In this community **50 yr.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Crawford** **28**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **5 miles E of Cherryville**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Nannie Cariloine Halbert**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **2** **widowed**

6. (b) Name of husband or wife **Singleton** 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased **Oct. 28 1856**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	89	2	7	hr. _____ min.

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

10. Usual occupation **housewife**

11. Industry or business **II**

MOTHER FATHER

12. Name ~~XXXXXX~~ **unknown**
13. Birthplace **unknown Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **II Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Thurston Halbert**
(b) Address **Steelyville, Missouri.**

17. (a) **burial** (b) Date thereof **1-8-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **restovers**

18. (a) Signature of funeral director **Thomas S. Halbert**
(b) Address **Steelyville, Missouri.**

19. (a) **2-10-46** (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **5** year **1946** hour **10** minute _____ M.

21. I hereby certify that I attended the deceased from **Dec 30** 19**45** to **Jan 5** 19**46**
that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Emphysema**
and coronary atherosclerosis

Due to _____

Due to _____

Other conditions _____

Major findings: Of operations _____

Of autopsy _____

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 **R. B. Parker** (M. D. or other) _____

Address **Steelyville, Mo** Date signed **1-21-46**

ADDITIONAL INFORMATION REQUESTED

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

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

RECEIVED

District Health Officer No. 8

District File Number 246273

Date Filed 2. 15. 46

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 88

Primary Registration District No. 5-325-

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Rural Courtois
(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

3. (a) PRINT FULL NAME Nannie C. Halber

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

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 Oct 2
(Month) (Day) (Year)

8. AGE: Years 89 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Bronchial pneumonia

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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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 R. B. Parker (M. D. or other) _____

Address Starkville, Mo Date 7-23-46

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

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

5069