

FILED APR 22 1946

State File No. _____

Registration District No. 177Primary Registration District No. 1002Registrar's No. 1679

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day 5 hrs.
 (Specify whether
 In this community 19 months
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. 224 E. 33 8
 (If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country _____ X

3. (a) PRINT FULL NAME Baby Richard Lee Hall

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

4. Sex male o 5. Color or race white 6. (a) Single o, widowed, married, divorced, infant o

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

7. Birth date of deceased September 6 1944
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>7</u>	<u>0</u>	hr. _____ min.

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

10. Usual occupation child11. Industry or business X12. Name Joseph P. Hall13. Birthplace Missouri o
 (City, town, or county) (State or foreign country)14. Maiden name Frances Lave15. Birthplace Missouri o
 (City, town, or county) (State or foreign country)16. (a) Informant Joseph P. Hall(b) Address 224 East 33rd St., K. C., Mo.17. (a) burial (b) Date thereof 4-9-46
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Greenlawn Cemetery18. (a) Signature of funeral director Stine & McClure(b) Address 3236 Gillham Plaza, K. C., Mo.19. (a) 4-9-46 (b) Geraldine Holmes
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
 year 1946 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from April 5 46 to April 6 46
 that I last saw him alive on April 6 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Undetermined
pending further investigation

Due to _____

Due to _____

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy See above

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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 W. W. Hart (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 4-8-46

Dr. J. J. ...

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 *[Signature]*
Licensed Embalmer No. *415*
P. O. Address *[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 DEATHState File No. 1679Registration District No. 149Primary Registration District No. 1002Registrar's No. 3443

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Manassas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Gen. Hosp. #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 1 day 5 hrs. (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Richard Lee Hall

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

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

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

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

8. AGE: Years 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.....

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) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-9-46 (Date received local registrar) (b) Geraldine Holmes (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 April day 6 year 1946 hour 4 minute 150 M.21. I hereby certify that I attended the deceased from April 5 1946 to 4-6 1946 that I last saw him alive on 4-6 1946 and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

encephalitis non epidemic

Due to.....

Due to etiology unknownOther conditions..... (Include pregnancy within 3 months of death) 80's

Major findings: Of operations.....

Of autopsy..... above

If death 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 Wm. W. Hart (M. D. or other).....Address Gen. Hosp. #1 Date signed 4-8-46

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **3414**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town.....
 (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

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 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 { 12. Name.....
 FATHER { 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?..... 13153 (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....
 that I last saw h..... alive on....., 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
 Due to.....
 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.

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.....