S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

12060

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 6 1946

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 13154

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1935

**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: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 weeks (Specify whether years, months or days)
In this community: all his life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Missouri (b) County: Jackson,
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: Rockhill Manor
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country: x

3. (a) PRINT FULL NAME: Ritchey C. Hallar,
3. (b) If veteran, name war: no.
3. (c) Social Security No. 496-07-5998
4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Mrs. Maud Stevens Hallar
6. (c) Age of husband or wife if alive: 69 years
7. Birth date of deceased: January (Month) 18 (Day) 1871 (Year)
8. AGE: Years 75 Months 3 Days 8 If less than one day hr. min.
9. Birthplace: Independence, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Assistant Vice President
11. Industry or business: McKesson-Robbins Drug Co.
FATHER 12. Name: Cephas Ritchey Hallar
FATHER 13. Birthplace: Missouri (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: unknown,
MOTHER 15. Birthplace: unknown, (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Maud Stevens Hallar,
(b) Address: Rockhill Manor, Kansas City, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 4-29-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill Cemetery
18. (a) Signature of funeral director: Stine & McClure
(b) Address: 3235 Gillham Plaza, K. C., Mo.
19. (a) 4-26-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 26 year 1946 hour 8:22 minute A. M.
21. I hereby certify that I attended the deceased from 8 april 46, 19..., to 26 april 19 46 that I last saw him alive on 25 april 19 46 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Cardiac Failure | 6 days |
| Due to: CHRONIC Myo-carditis + Uraemia due to | 3 weeks |
| Due to: cardiac failure, cardiac dilatation. | |
| Other conditions (Include pregnancy within 3 months of death): | |

Major findings:
Of operations: 9 3 d
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: Carl H. Lindquist (M. D. or other)
Address: 106 W 14th Date signed: 26 April

(Licensed Embalmer's Statement on Reverse Side)

Dr. Welker

Kell

August

## 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. 1415

P. O. Address R. C. 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.**