

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 178

Primary Registration District No. 5661

Registrar's No. 53

1. PLACE OF DEATH:

(a) County Lewis  
(b) City or town Rural, Highland, Township  
(c) Name of hospital or institution: County Home 5  
(d) Length of stay: In hospital or institution 20 Years  
In this community 20 Years

3. (a) PRINT FULL NAME Henderson Hall

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

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

6. (b) Name of husband or wife Bell Hall 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 14th, 1862

8. AGE: Years 84 Months 0 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Lewis County Missouri

10. Usual occupation not given

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Hall  
13. Birthplace Missouri  
14. Maiden name Unknown  
15. Birthplace \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address La Grange, Missouri

17. (a) Burial (b) Date thereof 5/11/46

(c) Place: burial or cremation La Grange Mo.

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

(b) Address La Grange, Missouri

19. (a) 5-15-46 (b) P. M. Jennings

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis  
(c) City or town Rural, Highland Township  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9  
year 1946 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 9 to May 19  
that I last saw him alive on May 9 and that death occurred on the date and hour stated above.

Immediate cause of death Conjunctive Heart failure  
Due to Pneumtic Heart disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Major findings: Of operations yes  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 5/19/46

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

RECEIVED  
District Health Officer No. \_\_\_\_\_  
District File No. 6-46-11  
Date JUN 13 1946

**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.....

**A.A. Roberts**

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *A.A. Roberts*

Licensed Embalmer No. 1626

P. O. Address La Grange, Missouri.

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 178Primary Registration District No. 5661Registrar's No. 53

## 1. PLACE OF DEATH:

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

Henderson Hall  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex... M 5. Color or race... B 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... April 14 1908  
 (Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 0 (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

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

10. Usual occupation... NOT GIVEN

11. Industry or business... NOT GIVEN

12. Name... William Hall

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

14. Maiden name... Unknown

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 5-15-46 (b) P. W. Jennings, M.D.  
 (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 \_\_\_\_\_, 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 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

**SUPPLEMENTARY**

Duration

PHYSICIAN

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

17244