

FILED APR 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14627

State File No. ....

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 101

## 1. PLACE OF DEATH:

(a) County Randolph  
 (b) City or town Moberly  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Woodland Hospital  
 (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

Thomas C. Hall3. (b) If veteran, name war. 3. (c) Social Security No. 4. Sex Male5. Color or race White6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased

Aug  
(Month)31<sup>st</sup>  
(Day)1865  
(Year)

8. AGE:

Years

Months

Days

If less than one day

81716

hr.

min.

9. Birthplace

(City, town, or county)

(State or foreign country) Mo10. Usual occupation Retired

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

12. Name John W. Hall

13. Birthplace

(City, town, or county)

(State or foreign country) Ill14. Maiden name Mary Pickett

15. Birthplace

(City, town, or county)

(State or foreign country) Ill16. (a) Informant Mrs T. H. Jones(b) Address Moberly17. (a) Burial  
(Burial, cremation, or removal)(b) Date thereof Apr 19-47  
(Month) (Day) (Year)(c) Place: burial or cremation Centralia, Mo18. (a) Signature of funeral director Mahan and Son(b) Address Moberly Mo19. (a) 4-18-47  
(Date received local registrar)(b) Leah E. McQueen  
(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph  
 (c) City or town Moberly  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 303 So Williams  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 17  
year 1947 hour 4 minute A M.21. I hereby certify that I attended the deceased from April 14  
1947, to April 17, 1947  
that I last saw him alive on Apr 16, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death

Acute Toxic Myocarditis  
and Toxic Nephritis chronic  
Cerebral Spinal Meningitis  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Duration

Due to

Due to

PHYSICIAN

Major findings:

Of operations \_\_\_\_\_

Of autopsy 6

ADDITIONAL  
 SUPPLEMENTARY  
 INFORMATION  
 REQUESTED

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? \_\_\_\_\_

(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 023. Signature W. H. Fleming (M. D. or D. O.)Address Moberly Mo Date signed April 17, 47

RECEIVED  
District Health Officer No. 1  
District File Number 4-47-674  
Date Filed APR 21 1947

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 Frank D. Kelt  
Licensed Embalmer No. 3021  
P. O. Address Moberly Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 14627-

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Randolph  
(b) City or town Manchester  
(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

Thomas C. 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 Aug. 31, 1855  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 April day 7  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

acute toxic myocarditis

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

Cerebral spinal meningitis

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

due to meningococcus

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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) (a) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed 8/12/48

Duration \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MAY 1948

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

