

No. 2
-12-45
5-17-39
P1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18534**

FILED MAY 21 1947

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 162

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 hrs.
(Specify whether
In this community Years, number unknown.
years, months or days)

3. (a) PRINT FULL NAME MILLIE C. HALTER - (EMPLOYEE)
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thomas E. Halter
6. (c) Age of husband or wife if alive Age Unknown
7. Birth date of deceased January 20, 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 3 19hr.min.

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

10. Usual occupation Night Attendant

11. Industry or business Mo. State Hospital No. 4

MOTHER FATHER

12. Name Henry E. Boyd

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

14. Maiden name Emma Johnson

15. Birthplace Minnith, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 5-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francois Memorial Park

18. (a) Signature of funeral director Miller Funeral Home
(b) Address Farmington, Missouri

19. (a) 5-12-47 (b) Ether Rudolph
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Farmington
(If outside city or town limits, write "RURAL")
(d) Street No. West Columbia
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9,
year 1947 hour 7 minute 20 A. M.

21. I hereby certify that I attended the deceased from
May 8, 1947, 19 to May 9, 1947, 19 ;
that I last saw her alive on May 9, 1947, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus Septicemia Duration 2 das.
Due to Cellulitis of the nose 3 das.

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy No 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? Cem.

While at work?..... (Specify type of place) (e) Means of injury 0

23. Signature John B. Bolman M.D. (M. D. or other)
Address State Hosp #9, Farmington, Mo 5/9/47

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

RECEIVED

District Health Officer No. 4
District File Number 542-226
Date Filed 5-20-47

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 Paul H. Royal
Licensed Embalmer No. 4120
P. O. Address Livingston 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.