

FILED AUG 26 1947
Registration District No. **293**

Primary Registration District No. **6005**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **Pallas**

(b) City or town **New London**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
R.H.D. New London Mo.
(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 **Elizabeth Gonn Halse**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased **Sept. 1, 1887**
(Month) (Day) (Year)

8. AGE: Years **59** Months **11** Days **12**
If less than one day hr. _____ min.

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

10. Usual occupation **Homemake**

MOTHER {

11. Industry or business _____

12. Name **William P Gonn**

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

14. Maiden name **Fannie Bowling**

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

16. (a) Informant **W.E. Gonn**

(b) Address **R.H.D. New London Mo**

17. (a) **Burial** (b) Date thereof **Aug. 18, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Barkley Cem.**

18. (a) Signature of funeral director **James O'Donnell**

(b) Address **Hannibal Mo**

19. (a) **8-19-47** (b) **H. F. Waters**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pallas**

(c) City or town **New London**
(If outside city or town limits, write "RURAL")

(d) Street No. **Rural**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **12** year **1947** hour _____ minute **3:25 P.M.**

21. I hereby certify that I attended the deceased from **Jan 46** to **Aug 12**, 19**47**
that I last saw her alive on **Aug 1**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardio-vascular**

Due to **Renal Disease**

Due to _____

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) (e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) _____
Address **[Signature]** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Aug 14 - 47

RECEIVED
District Health Officer No. 11
District File Number 8-47-109
Date Filed AUG-25-1947

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. 497
working under my personal supervision.

Signed H. M. O'Connell
Licensed Embalmer No. 3889
P. O. Address Hannibal 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.

Registration District No. 293

Primary Registration District No. 6005

1. PLACE OF DEATH:

(a) County Rath
(b) City or town Rural
(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) (Specify whether

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.....

3. (a) PRINT FULL NAME Elizabeth C Hulse

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

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

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

7. Birth date of deceased Sept 1 1942
(Month) (Day) (Year)

8. AGE: Years 59 Months 4 Days 2 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business.....

MOTHER, FATHER { 12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name..... (State or foreign country)
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) Aug 31, 1979 (b) H. A. Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... 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 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).....
Date signed.....

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

SUPPLEMENTARY

S-28675