

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37870**  
Registrar's No. **88**

FILED NOV 28 1947  
**733**

Registration District No. \_\_\_\_\_ Primary Registration District No. **3022**

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

**1. PLACE OF DEATH:**

(a) County Harrison

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

(c) Name of hospital or institution:  
Bethany Hospital.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days.  
20 yrs.  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Benjamin Charles Hall

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Catherine.

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased January 11, 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day hr. min.
	72	10	27	

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

10. Usual occupation Farmer

11. Industry or business XX

12. Name Francis M. Hall

13. Birthplace No. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Savannah Finley

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

16. (a) Informant Clinton Hall  
(b) Address Marshalltown, Ia.

17. (a) Burial  
(Burial, cremation, or removal) (b) Date thereof 11-10-1947  
(Month) (Day) (Year)

(c) Place of burial or cremation Antioch (Bethany, Mo.)

18. (a) Signature of funeral director McKean  
(b) Address Bethany, Mo.

19. (a) Nov. 10 1947 (b) Zola Burris  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Harrison **41**

(c) City or town Bethany (Rural)  
(If outside city or town limits, write "RURAL") **0**

(d) Street No. 3 miles South  
(If rural, give location) **0**

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no **0**

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov day 8  
year 1947 hour 2 minute 25 P.M.

21. I hereby certify that I attended the deceased from 5 Nov. 1947, to 8 Nov. 1947  
that I last saw him alive on 8 Nov. 47 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral injury

Due to Bullet wound.

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

Other conditions 766  
(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) homicide

(b) Date of occurrence 5 Nov. 47

(c) Where did injury occur? Harrison Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
It was

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Postal

23. Signature Louis B. Panting (M. D. or other)  
Address Bethany Mo. Date signed 10 Nov 47

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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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.....

  
M. B. Haas.

Licensed Embalmer NO. 3899

P. O. Address. Bethany, 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.