

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

2 47 39

National Office of Vital Statistics

State File No.

FILED MAR 15 1948

Registration District No. 2

Primary Registration District No. 4008

Registrar's No. 232

1. PLACE OF DEATH:

(a) County: Andrew  
(b) City or town: Cosby  
(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: 20 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Andrew  
(c) City or town: Cosby  
(If outside city or town limits, write "RURAL")  
(d) Street No.:  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country:

3. (a) PRINT FULL NAME: William Henry Hall

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

4. Sex: m, Color or race: W, divorced: m  
5. (b) Name of husband or wife: LOU ANNA HALL  
6. (c) Age of husband or wife if alive: 78 years  
7. Birth date of deceased: Dec 15 - 1874  
(Month) (Day) (Year)

8. AGE: Years 73, Months 2, Days 17  
If less than one day: hr. min.

9. Birthplace: CLARKSDALE MO  
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:  
12. Name: John Hall  
13. Birthplace: Liberty MO  
(City, town, or county) (State or foreign country)  
14. Maiden name: JANE ANN CLARK  
15. Birthplace: ST. LO OHIO  
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Louanna Hall  
(b) Address: Cosby MO

17. (a) BURIAL (b) Date thereof: 3-4-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: High Prairie

18. (a) Signature of funeral director: E. C. Breit  
(b) Address: Savannah MO

19. (a) 3-4-48 (b) Fullman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Mar, day: 2, year: 1948, hour: 8:00, minute: 30 A.M.  
21. I hereby certify that I attended the deceased from: Feb 2, 1948, to: Mar 2, 1948  
that I last saw h.i.m. alive on: Feb 28, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion  
Due to: Chronic myocarditis

Other conditions: (Include pregnancy within 3 months of death)  
Major findings: Of operations: A2B  
Of autopsy:  
PHYSICIAN: Underline the cause of 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: 2

23. Signature: H. R. Bidentice (M.D. or other) DO  
Address: St. Joseph, MO Date signed: 3/2/48

**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.....

*E. C. Breit*

Licensed Embalmer No.....

*2650*

P. O. Address.....

*Savannah 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.

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(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 Wm H. Hall

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

4. Sex M 5. Color or race w 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Dec 15 (Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Retired Farmer

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 \_\_\_\_\_ (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 \_\_\_\_\_ Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M. 2

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

1948  
60-82-5