DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 23 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25246

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 93

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Nevada Twp (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)
In this community 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Vernon
(c) City or town Marshfield (If outside city or town limits write "RURAL")
(d) Street No. ✓ (If rural, give location)
(e) If foreign born, how long in U. S. A.? ✓ years

3. (a) PRINT FULL NAME MARION HALL
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mrs Marion Hall
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Unknown (Month) (Day) (Year)
8. AGE: Years about 70 Months ✓ Days ✓ If less than one day ___ hr. ___ min.
9. Birthplace Unknown (City, town, or county) (State or foreign country) U
10. Usual occupation Farmer
11. Industry or business
MOTHER 12. Name Unknown U
FATHER 13. Birthplace ✓ (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace ✓ (City, town, or county) (State or foreign country) U
16. (a) Informant Hospital record
(b) Address Nevada, Mo.
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof July 15-48 (Month) (Day) (Year)
(c) Place: burial or cremation Marshfield Mo
18. (a) Signature of funeral director [illegible]
(b) Address Marshfield Mo
19. (a) 7-14-48 (Date received by local registrar) (b) Kathryn Yancey (Registrar's signature) 32

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 13 day 13 year 1948 hour 9 minute 45 A.M.
21. I hereby certify that I attended the deceased from 7-2-48, 1948 to 7-13-48, 1948 that I last saw him alive on 7-12-48, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerotic Heart disease	
Due to Meningo-encephalitis	
Due to ✓	
Other conditions ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓ Of 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? (Specify type of place)
While at work?
(e) Means of injury ✓

23. Signature [illegible] M.D. (M. D. or other)
Address Nevada Mo Date signed 7-13-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 814
Date Filed 7-22-4

JUL 22 194

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 .....

Licensed Embalmer No. 3312

P. O. Address Marsh Indiff

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.