

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33479

State File No. ....

FILED NOV 1 1948

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 138

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

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Chillicothe  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
207 Slack Street /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days) 14 years (Specify whether

3: (a) PRINT FULL NAME John 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 Sarah E. Bland 6. (c) Age of husband or wife if alive D years  
7. Birth date of deceased February 20 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 7 29 hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Granville Hall  
13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Christiana Decker  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. May Jones

(b) Address Chillicothe, Missouri

17. (a) Burial (b) Date thereof 10-21-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Enid Cemetery

18. (a) Signature of funeral director Norman Funeral Home

(b) Address Chillicothe, Missouri

19. (a) Oct-19-48 (b) Frances B. Neil  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston 59  
(c) City or town Chillicothe  
(If outside city or town limits, write "RURAL")  
(d) Street No. 207 Slack Street  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 19th  
year 1948 hour 4 minute 40 A M.

21. I hereby certify that I attended the deceased from Oct 17  
1948, to Oct 19, 1948;  
that I last saw him alive on Oct 18, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute congestive heart failure  
Due to \_\_\_\_\_  
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?

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

23. Signature Joseph F. Gale (M. D. gale)  
Address Chillicothe, Mo Date signed 10-19-48

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 Elton A. ...

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri

**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.**