FILED MAR 2 1949

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7191

BIRTH NO. ____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 35

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Wash. Twp.
c. LENGTH OF STAY (If hospital, give dates) 26-6-27
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Hickory
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Almon
d. STREET ADDRESS (If rural, give location) ✓

43 0 1 0

3. NAME OF DECEASED (Type or Print) a. (First) ALLAN ~~Hall~~ b. (Middle) c. (Last) HALL

4. DATE OF DEATH (Month) (Day) (Year) 2-18-1949

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single (1) 8. DATE OF BIRTH 5-6-1871 9. AGE (In years last birthday) 77 IF UNDER 1 YEAR Months 9 Days 12 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (State or foreign country) Mo
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME G. C. Hall
13b. MOTHER'S MAIDEN NAME Elizabeth Trotter
14. NAME OF HUSBAND OR WIFE Single

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ✓
17. INFORMANT'S SIGNATURE OR NAME Hospital record ADDRESS Nevada, Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocarditis
DUE TO (c) ✓

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Epilepsy

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION ✓
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-8-, 1949, *to* 2-18-, 1949, *that I last saw the deceased alive on* 2-18, 1949, *and that death occurred at* 5:30 A m. *from the causes and on the date stated above.*

23a. SIGNATURE R G Hall (Degree or title) M.D.
23b. ADDRESS Nevada Mo
23c. DATE SIGNED 2-18-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 2-17-49
24c. NAME OF CEMETERY OR CREMATORY Hospital Cemetery
24d. LOCATION (City, town, or county) (State) Nevada, Mo

DATE REC'D BY LOCAL REG. Feb. 24, 1949
REGISTRAR'S SIGNATURE 331 Kathryn H. Yancey
25. FUNERAL DIRECTOR'S SIGNATURE Eichenger Funeral Home
ADDRESS Nevada Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 7
District File Number 1-49-138
Date Filed 2-28-49

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 _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Student Embalmer

Signed Marsh Eichinger
Licensed Embalmer No. 2656.

P. O. Address _____

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

If this body is not embalmed, fact should be so stated above.