

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42215**

No. 300
10-48

Filed Jan. 6, 1950
36120-49

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

BIRTH NO. 124		REG. DIST. NO. 316	PRIMARY REG. DIST. NO. 4462	Registrar's No. 461
1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY St. Francois		
b. CITY (If outside corporate limits, write RURAL and give township) Elvins, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) Elvins		
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) Dorothy		b. (Middle) Ruth		c. (Last) Hall
4. DATE OF DEATH (Month) (Day) (Year) Dec. 19, 1949		5. SEX Female		
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH May 7, 1949
9. AGE (In years last birthday) 7 12		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Leon Hall		13b. MOTHER'S MAIDEN NAME Georgi Lee Hampton		14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Leon Hall
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Spinal Bifida ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hydrocephalus DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 751X
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from May 7, 1949 , to 12-19, 1949 , that I last saw the deceased alive on June 1, 1949 , and that death occurred at 2:30 p.m. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) W. Hoffman M.D.		23b. ADDRESS Bismarck Mo		23c. DATE SIGNED 12-21-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 21, 1949		24c. NAME OF CEMETERY OR CREMATORY Madame Cemetery
24d. LOCATION (City, town, or county) (State) Bismarck Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Raymond Caldwell		
DATE REC'D BY LOCAL REG. Dec. 31, 1949		REGISTRAR'S SIGNATURE Ether R. D. ...		ADDRESS Flat River

(Licensed Embalmers' Statement on Reverse Side)

RECEIVED 1-9-50

Health Officer No. 4

File Number 150-4

Date Filed

JAN 13 1950

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 R. Caldwell

Licensed Embalmer No. 2531

P. O. Address Flat River 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.