

FILED NOV 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36960**

03915

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 957

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield <u>03915</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 2170 N. Pierce	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) JAMES	b. (Middle) M.	c. (Last) HALL	4. DATE OF DEATH (Month) (Day) (Year) Nov 9, 51
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 10, 1897	9. AGE (In years last birthday) 54	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Bolivar Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Eaff Hall	13b. MOTHER'S MAIDEN NAME (?) Lloyed	14. NAME OF HUSBAND OR WIFE Edith Hall
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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. 491-05-1460	17. INFORMANT'S SIGNATURE OR NAME Edith Hall, Spfld. Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic bronchial DUE TO (c) Peltona		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 241X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct 26, 1951, to Nov. 9, 1951, that I last saw the deceased alive on Nov. 9, 1951, and that death occurred at 8:30pm., from the causes and on the date stated above.

23a. SIGNATURE Edward Marcus M.D.	(Degree or title)	23b. ADDRESS Woodruff Bldg	23c. DATE SIGNED 11/11/51
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 11-12-51	24c. NAME OF CEMETERY OR CREMATORY Danforth Cemetery	24d. LOCATION (City, town, or county) (State) Greene Co. Mo.
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DATE REC'D BY LOCAL REG. 11-13-51	REGISTRAR'S SIGNATURE W.C. Handrup	25. FUNERAL DIRECTOR'S SIGNATURE J.W. Klingner & Co	ADDRESS Spfld Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

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 W. H. Rhodes

Licensed Embalmer No. 40717

P. O. Address Quincy, Ill.

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.