

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **8399**

FILED MAR 10 1953

BIRTH NO. _____		REG. DIST. NO. 925		PRIMARY REG. DIST. NO. 4476		Registrar's No. 9	
1. PLACE OF DEATH a. COUNTY Schuyler				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Schuyler			
b. CITY (If outside corporate limits, write RURAL and give township) Downing		c. LENGTH OF STAY (In this place) 1 yr		c. CITY (If outside corporate limits, write RURAL and give township) Downing		0980	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print) a. (First) Charles		b. (Middle) Lillian		c. (Last) Hall		4. DATE OF DEATH (Month) (Day) (Year) Mar. 4, 1953	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Feb. 27, 1869	
9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Milton, Iowa	
10a.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Joseph Hall		13b. MOTHER'S MAIDEN NAME Mary Ryan	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Floyd Hall, Downing, 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.		18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Failing Compensation Heart 2 years ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) 4343				INTERVAL BETWEEN ONSET AND DEATH 2 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Tropical causing Shortness of Breath		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) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Downing Mo.		21d. HOW DID INJURY OCCUR? None	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from Dec. 1952 , to Feb 26, 1953 , that I last saw the deceased alive on 2/26/1953 , and that death occurred at 4 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE H. E. Gerwig		(Degree or title) M.D.		23b. ADDRESS Downing Mo.		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 6, 1953		24c. NAME OF CEMETERY OR CREMATORY Queen City		24d. LOCATION (City, town, or county) (State) Queen City, Mo.	
DATE REC'D BY LOCAL REG. Mar. 5, 1953		REGISTRAR'S SIGNATURE 35		25. FUNERAL DIRECTOR'S SIGNATURE Moore Funeral Home Downing Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

980
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed

Neal Payne

Signed.....

Student Embalmer

Licensed Embalmer No. *2550*

P. O. Address

Memphis 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.