

FILED AUG 31 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28158

State File No. \_\_\_\_\_  
Registrar's No. 53-80

BIRTH NO. _____		REG. DIST. NO. 93		PRIMARY REG. DIST. NO. 4153		Registrar's No. 53-80			
1. PLACE OF DEATH a. COUNTY Dade				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Dade					
b. CITY OR TOWN Lockwood		c. LENGTH OF STAY (in this place) 1 yr		c. CITY OR TOWN Lockwood Mo 9290					
d. FULL NAME OF HOSPITAL OR INSTITUTION Home				d. STREET ADDRESS (If rural, give location) @					
3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Fremont c. (Last) Hall			4. DATE OF DEATH (Month) (Day) (Year) Aug 22 1953						
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH May 6, 1892		9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 3 Days 16	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Arcadia Kans		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME George F. Hall			13b. MOTHER'S MAIDEN NAME Mollie Jones			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) No			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Nellie Parker Lockwood 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) Myocarditis ANTECEDENT CAUSES DUE TO (b) Arthritis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 725X						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 Aug 6, 1953, to 8-22, 1953, that I last saw the deceased alive on Aug 22, 1953, and that death occurred at 2:00 P.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) James W. Wren MD				23b. ADDRESS Lockwood Mo			23c. DATE SIGNED 8-25-53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-25-1953	24c. NAME OF CEMETERY OR CREMATORY Sinking Creek		24d. LOCATION (City, town, or county) (State) Wade Co. Mo				
DATE REC'D BY LOCAL REG. 8-25-53		REGISTRAR'S SIGNATURE J. C. Canada 4787			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.R. Allison Sheffield Mo.				

**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.R. Allison*

Licensed Embalmer No. *4404*

P. O. Address *Greenfield 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.