No. 300
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FILED JAN 25 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 45151

BIRTH NO. _____ REG. DIST. NO. 214 PRIMARY REG. DIST. NO. 4394 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Ozark
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bakersfield Mo.
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Ozark 0770 0
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bakersfield Mo.
d. STREET ADDRESS (If rural, give location): Bakersfield Mo

3. NAME OF DECEASED (Type or Print)
a. (First): Serrell
b. (Middle): Walter
c. (Last): Halford

4. DATE OF DEATH (Month) (Day) (Year): 11 - 25 - 53

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 1
8. DATE OF BIRTH: 1-23-1876
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months 10, Days 2 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Barter Co. Ark. 1
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: James Halford
13b. MOTHER'S MAIDEN NAME: Irena Bean
14. NAME OF HUSBAND OR WIFE: Rosie Halford

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: Rosie Halford — **ADDRESS**: Bakersfield 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) Chronic myocardial Heart disease
DUE TO (b) arteriosclerosis
DUE TO (c)

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

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: 4-2-21
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan 1, 1948, *to* 11-29, 1953, *that I last saw the deceased alive on* 11-28, 1953, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eldon W Chamber (M.D.)
23b. ADDRESS: Mountain Grove Mo.
23c. DATE SIGNED: 12-10-53

24a. BURIAL, CREMATION, REMOVAL (Specify): B
24b. DATE: 11/29/53
24c. NAME OF CEMETERY OR CREMATORY: Hawkins Ridge
24d. LOCATION (City, town, or county) (State): Bakersfield Mo.

DATE REC'D BY LOCAL REG.: JAN 25 1954
REGISTRAR'S SIGNATURE: Clyde A. Bridges
25. FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS**: Robertson West Plains, Mo

(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 D. D. Robertson

Licensed Embalmer No. 3432

P. O. Address West Plain 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.