

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11179**

FILED APR 21 1954

REG. DIST. NO. **32** PRIMARY REG. DIST. NO. **4443** Registrar's No. **914**

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

1. PLACE OF DEATH a. COUNTY Ballinger		2. USUAL RESIDENCE (Where deceased lived. If limitation: residence before admission) a. STATE Mo b. COUNTY New Madrid	
b. CITY OR TOWN Marble Hill		c. CITY (If outside corporate limits, write RURAL and give township) Matthews 0720	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ballinger Nursing Home		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) H. c. (Last) HALE		4. DATE OF DEATH (Month) (Day) (Year) Apr 3 1954	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Oct 30, 1866
9. AGE (In years last birthday) 87		10. KIND OF BUSINESS OR INDUSTRY Farm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (City and State or Foreign Country) Mississippi County	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Frank Hale	
13b. MOTHER'S MAIDEN NAME Ann Overman		14. NAME OF HUSBAND OR WIFE Emma Hale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Frank Hale Matthews		ADDRESS	
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) Pyoderma ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION arteriosclerosis	
19c. INTERVAL BETWEEN ONSET AND DEATH		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) (Min.)	
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 7-22 , 19 53 , to Apr 3 , 19 54 , that I last saw the deceased alive on 1-15 , 19 54 , and that death occurred at 9 PM AM from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Ch. Nienstedt MD		23b. ADDRESS Ekerton Mo	
23c. DATE SIGNED 4-8-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 4-15-54		24c. NAME OF CEMETERY OR CREMATORY Matthews Cem.	
24d. LOCATION (City, town, or county) (State) Matthews Mo		25. FUNERAL DIRECTOR'S SIGNATURE Orville Doyle Ekerton, Mo.	
DATE REC'D BY LOCAL REG. 4-10-54		REGISTRAR'S SIGNATURE Nellie Van Amburgh	
25. FUNERAL DIRECTOR'S ADDRESS		ADDRESS	

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 Irish Marshall

Licensed Embalmer No. 4601

P. O. Address Sebastian 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.