

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19596**

FILED JUL 6 1954

BIRTH NO. _____		REG. DIST. NO. 195		PRIMARY REG. DIST. NO. 4308		Registrar's No. 47	
1. PLACE OF DEATH a. COUNTY McDonald				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY McDonald			
b. CITY (If outside corporate limits, write RURAL and give township) Noel		c. LENGTH OF STAY (In this place) 50 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) Noel		0600	
d. FULL NAME OF HOSPITAL OR INSTITUTION None				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED a. (First) John b. (Middle) Edward c. (Last) Hall			4. DATE OF DEATH (Month) (Day) (Year) 6-24-54				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 28, 1880	
9. AGE (In years last birthday) 73		10. MONTHS 10		11. DAYS 26		12. IF UNDER 1 YEAR Hours Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (City and State or Foreign Country) Murfreesboro Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME John R. Hall			13b. MOTHER'S MAIDEN NAME Elza Crisenberry		14. NAME OF HUSBAND OR WIFE Ina Hall		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Ina Hall			
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) Hydrostatic pneumonia					INTERVAL BETWEEN ONSET AND DEATH 4 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Sarcocystis Caudata		DUE TO (c) Cerebral Vascular Accident			2 mo
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Cardiac decompensation					3 yrs.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331 X					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 6-7, 1954 , to 6-24, 1954 , that I last saw the deceased alive on 6-24, 1954 , and that death occurred at 8:15 P m. , from the causes and on the date stated above.							
23a. SIGNATURE Willard L. Stille, M.D.			23b. ADDRESS Noel Mo.			23c. DATE SIGNED 6-30-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 6-27-1954		24c. NAME OF CEMETERY OR CREMATORY North Union		24d. LOCATION (City, town, or county) (State) Noel Mo.	
DATE REC'D BY LOCAL REG. 6-30-54		REGISTRAR'S SIGNATURE Wayne Humphrey		25. FUNERAL DIRECTOR'S SIGNATURE W.M. Humphrey		ADDRESS Noel Mo.	

0600

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 *H. M. Humphrey Jr.*

Licensed Embalmer No. 4708

P. O. Address Truel 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.