

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041445

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 248 STATE FILE NUMBER

FILED DEC 13 1961

| | | | | | |
|--|---|---|---|--|--|
| 1. PLACE OF DEATH | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | |
| a. COUNTY JASPER | | | a. STATE MO. b. COUNTY JASPER | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CARTHAGE | | Length of stay in 1b 1 YEAR | c. CITY OR TOWN CARTHAGE | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MCCUNE BROOKS HOSPITAL | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 834 E. HIGHLAND | |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First SARA Middle BAY Last HALL | | | Month DEC. Day 8, Year 1961 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 12, 1874 | 9. AGE (last birthday) 87 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOMEMAKING | 11. BIRTHPLACE (City and state or country) WELLINGTON, MO. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME MATTHEW VAN LEAR MCC | | 13b. MOTHER'S MAIDEN NAME ELLAND *SARA ELIZABETH BAY* | | 14. NAME OF HUSBAND OR WIFE WM. TILESTON HALL | |
| 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. NONE | | 17. INFORMANT Address MRS. FRANK JONES, JR., CARTHAGE, MO. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Hypostatic Pneumonia, terminal | | | | | 10 days +, - |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | Yrs. ? |
| DUE TO (b) Cerebral Arteriosclerosis | | | | | Yrs. ? |
| DUE TO (c) Generalized Arteriosclerosis | | | | | Yrs. ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from August 3, 1951 to December 8, 1961 and last saw her her on December 8, 1961 Death occurred 8:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>W Russell Smith</i> | | | 22b. ADDRESS M.D. 211 E. CHESTNUT, CARTHAGE, MO. | | 22c. DATE SIGNED 12-8-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 12-11-61 | 23c. NAME OF CEMETERY OR CREMATORY MACHPELAH | | 23d. LOCATION (City, town, or county) (State) LEXINGTON, MO. | |
| 24. FUNERAL DIRECTOR ADDRESS ULMER FUNERAL HOME, CARTHAGE, MO. | | | 25. DATE RECD. BY LOCAL REG. 12-9-61 | 26. REGISTRAR'S SIGNATURE <i>E. J. Clinton</i> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 _____
Signature of Student Embalmer

Signed Melvin Gavel

Licensed Embalmer No. 5121

P. O. Address CARTHAGE, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.