WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 22937a

PLACE OF DEATH

County Henry

Township or Village or City Deepwater (No. St.: Ward)

Registration District No. 351 File No.

Primary Registration District No. 4208 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James W. Hallagin

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX M; COLOR OR RACE W; SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widower	DATE OF DEATH June 28 (Month) (Day), 1918 (Year)
DATE OF BIRTH Aug 28, 1839 (Month) (Day) (Year)	I HEREBY CERTIFY, that I attended deceased from May 9, 1918, to June 28, 1918, that I last saw him alive on Sometime in June 1918,
AGE 78 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?	and that death occurred, on the date stated above, at 1 P m.
OCCUPATION (a) Trade, profession, or particular kind of work Black Smith; (b) General nature of industry, business, or establishment in which employed (or employer) General Work	The CAUSE OF DEATH* was as follows: Brights disease of Kidneys and old age
BIRTHPLACE (City or town, State or foreign country) Scott Co Iowa	(Duration) 1 yrs. mos. ds.
NAME OF FATHER dont Know	Contributory (Secondary) over work (Duration) yrs. mos. ds.
BIRTHPLACE OF FATHER (City or town, State or foreign country) Foreign Country	(Signed) O. W. Haward M. D. 6/29/ 1918 (Address) Deepwater
MAIDEN NAME OF MOTHER dont Know Ireland	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Foreign Country Ireland	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) O. W. Haward M D	Where was disease contracted if not at place of death? Former or usual residence
(ADDRESS) Deepwater	PLACE OF BURIAL OR REMOVAL K of P Cemetery; DATE OF BURIAL June 29, 1918
Filed Oct 10 1918 H. W. Morgan Depty REGISTRAR	UNDERTAKER W. H. McCan; ADDRESS Deepwater

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1____

(Month) (Day) (Year)

AGE

_____yrs. _____mos. _____ds.

If LESS than 1 day, ____hrs. or ____min.?

OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191__*

(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)____yrs.____mos.____ds.

Contributory _____
(SECONDARY)

_____(Duration)____yrs.____mos.____ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____yrs.____mos.____ds. In the State ____yrs.____mos.____ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191__
UNDERTAKER	**ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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