

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

Do not use this space

File No. 36568
Registered No. 5 St. _____ Ward _____

1. PLACE OF DEATH
County Scott Registration District No. 820
Township Sylvania Primary Registration District No. 4496
City Oran (No. _____) St. _____ Ward _____

2. FULL NAME Leon A. Halter
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 8, 1907

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>24</u>	<u>8</u>	<u>19</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work in school
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Anthony Halter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Cara Gerst

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Anthony Halter
(Address) Oran Mo

15. FILED 11/9, 1931 L. Shekman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/27 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 1931, to 10/27, 1931, that I last saw _____ alive on 7/26, 1931, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23P
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 23P
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) J. A. Cline, M. D.
, 19 Oran Mo (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Catholic Cemetery DATE OF BURIAL 10/29 1931

20. UNDERTAKER F. J. Heins ADDRESS Oran

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.

DEC 26 1931

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