

Registration District No. **816**

Primary Registration District No. **6065**

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Nelson
(c) Name of hospital or institution Near Nelson
(d) Length of stay: In hospital or institution four weeks
In this community four weeks

3. (a) PRINT FULL NAME W. E. O. HALTER
3. (b) If veteran, name war _____ **3. (c) Social Security No.** _____

4. Sex male **5. Color or race** white **6. (a) Single, widowed, married, divorced** widowed
6. (b) Name of husband or wife None **6. (c) Age of husband or wife if alive** 70 years
7. Birth date of deceased April 4 1865

8. AGE: Years 74 Months 8 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Oran Missouri

10. Usual occupation Farmer

11. Industry or business 6
12. Name Henry Halter
13. Birthplace Alsace Germany
14. Maiden name Sarah Kuhn
15. Birthplace Oran Missouri

16. (a) Informant's own signature Theon Halter
(b) Address 5203 Davison St St Louis Mo

17. (a) Oran Mo **(b) Date thereof** 2 14 1940
(c) Place: burial or cremation Oran Mo

18. (a) Signature of funeral director P. J. Messerer Co
(b) Address Oran Missouri

19. (a) 2/12/40 **(b) W. O. Jimmy**
(Date received local registrar) **(Registrar's signature)**

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Sylva
(c) City or town Oran
(d) Street No. RURAL
(e) If foreign born, how long in U. S. A.? yes years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 10
year 1940 hour 11:00 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from February 10 1940
to February 10 1940
that I last saw him alive on February 10 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza and pneumonia
Duration 2 days

Due to Infection and exposure

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings: NONE
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
(e) Means of injury _____
23. Signature W. O. Jimmy **(M. D. or other)** _____
Address Chaffee, Missouri **Date signed** 2-12-40

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

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.

Rev. 5-17-39
50M-5-17-39
1 X 1511

RECEIVED

District Health Officer No. 340-693

District File Number

Date Filed 3/7/40

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.....

~~Harvey J. [Signature]~~

....., Registered Apprentice No.

working under my personal supervision.

Not Emb.

Signed ~~Harvey J. [Signature]~~ (34)

Licensed Embalmer No.

P. O. Address ~~Suburban 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, above space should be left blank.