

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21461**

Registration District No. **156**

Primary Registration District No. **4090**

Registrar's No. **38**

1. PLACE OF DEATH:
 (a) County Cass
 (b) City or town Harrisonville Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7
(Specify whether
 In this community 6 weeks
years, months or days)

3. (a) PRINT FULL NAME Halley Belle Fox
 3. (b) If veteran, L name war L
 3. (c) Social Security No. L

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Andrew F. Fox
 6. (c) Age of husband or wife if alive L years
 7. Birth date of deceased Oct 17 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 3
 If less than one day — hr. — min.

9. Birthplace Peoria
(City, town, or county) (State or foreign country)

10. Usual occupation House maker

11. Industry or business L

MOTHER FATHER { 12. Name David M. Cardle
 13. Birthplace Pa
(City, town, or county) (State or foreign country)

14. Maiden name Jac Sweet

15. Birthplace Pa
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph G. Fox

(b) Address Harrisonville Mo

17. (a) Removed (b) Date thereof June 21 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairbank's
HUNNENBURGER'S

18. (a) Signature of funeral director HARRISONVILLE, MO.

(b) Address L

19. (a) 6/21/40 (b) L
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Cass
 (c) City or town Harrisonville
(If outside city or town limits, write "RURAL")
 (d) Street No. 402 S. Independence
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20
 year 1940 hour 11:55 minute P. M.

21. I hereby certify that I attended the deceased from May 23
1940, to June 20, 1940
 that I last saw her alive on June 20, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration June 18-20

Due to Hypertension ASC

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Chronic Myocarditis with degeneration

Major findings: L
 Of operations L
 Of autopsy L

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? L (Specify type of place) (e) Means of injury L

23. Signature Geo. C. Walden (M. D. or other) L
 Address Harrisonville Mo Date signed June 21 1940

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

980

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Frank E. Rummelberger
Licensed Embalmer No. 2691
P. O. Address Harrisonville

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 21461
Registrar's No. 38

Registration District No. 151

Primary Registration District No. 4090

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

1. PLACE OF BIRTH:

(a) County Cass
(b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Hallie Belle Fox

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced urd

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6/21/40 (b) [Signature] (Dates received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature Geo Welch (M. D. or other) _____
Address Harrisonville Date signed _____

SUPPLEMENTAL

