

Registered in District No. 65
FILED FEB 11 1944

Primary Registration District No. 4113

Registrar's No.

1. PLACE OF DEATH:
(a) County CHARITON
(b) City or town BRUNSWICK
(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 _____ (Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County CHARITON
(c) City or town BRUNSWICK
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LAFAYETTE H. HALLIBURTON
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JANUARY day 28 hour 2 minute A. M.
year 1944

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife WELL 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from 8 A.M. Jan 27, 1944 to 7 P.M. Jan 27, 1944
that I last saw him alive on Jan 27, 1944 and that death occurred on the date and hour stated above.

7. Birth date of deceased NOVEMBER 2-1881
(Month) (Day) (Year)

Immediate cause of death Dehydration
Gastric hemorrhage 2 days

8. AGE: Years 62 Months 7 Days 26 If less than one day _____ hr. _____ min.

Due to Chronic alcoholism?

9. Birthplace MACON Co., MO.
(City, town, or county) (State or foreign country)

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

10. Usual occupation RETIRED AUTO DEALER

Major findings:
Of operations none
Of autopsy none

11. Industry or business _____

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide (specify) _____

MOTHER FATHER
12. Name D. M. HALLIBURTON
13. Birthplace RANDOLPH Co., MO.
(City, town, or county) (State or foreign country)
14. Maiden name MARANDA J. WRIGHT
15. Birthplace MACON Co., MO.
(City, town, or county) (State or foreign country)

22. (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?
(Specify type of place) _____
(e) Means of injury _____

16. (a) Informant MRS. WELLS HALLIBURTON
(b) Address BRUNSWICK MO

22. (a) Signature of funeral director _____
(b) Address BRUNSWICK MO

17. (a) BURIAL (b) Date thereof 1-31-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

22. (c) Signature Harry E. Tatum (M. D. or other) _____
Address Brunsuwick Mo Date signed 1/28/44

(c) Place: burial or cremation BRUNSWICK MO

18. (a) Signature of funeral director _____
(b) Address BRUNSWICK MO
19. (a) 1-31-1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

22. (d) Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

RECEIVED

District Health DEPARTMENT NO. 3
District File Number
Date Filed 2-9-47

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 L. McEisail

Licensed Embalmer No. 823

P. O. Address Wrentham

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FEB 1

Registration District No. 65 Primary Registration District No. 4113 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Chariton

(b) City or town Brunswick
(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 _____ (Specify whether)
In this community _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jafayette H. Halliborton

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

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Nov. 2 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 2 Days no If less than one day

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 28 year 1944 hour _____ minute _____ M.

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

Immediate cause of death Dehydration 3 day
Gastric hemorrhage

Due to Gastritis from alcohol (drinking)

Due to Chronic alcoholism?

Other conditions no
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

JUN 5 1945

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