S. No. 2
I—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37386

Registration District No. 141 Primary Registration District No. 30-25 5551 Registrar's No. 118

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Rural Howell 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 ..... (Specify whether
In this community 11 mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell

(c) City or town Rural 46
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Elijah Hall

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

4. Sex M D 5. Color or race Wht 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Belle 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased 9 (Month) 29 (Day) (Year)

8. AGE: Years 69 Months Days If less than one day ..... hr. ..... min.

9. Birthplace Baxter Co (City, town, or county) Ark (State or foreign country)

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name Elisha Hall /
13. Birthplace Morgan Co (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Mary J. Webb
15. Birthplace Tenn (City, town, or county) / (State or foreign country)

16. (a) Informant Mabel Harris
(b) Address West Plains, Mo.

17. (a) B (Burial, cremation, or removal) (b) Date thereof 10/21/45 (Month) (Day) (Year)
(c) Place: burial or cremation Co Line

18. (a) Signature of funeral director Robertson
(b) Address West Plains, Mo.

19. (a) 11-6-1945 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 18
year 45 hour 3:30 minute A M.

21. I hereby certify that I attended the deceased from 10-18, 1945, to 10-18, 1945
that I last saw him alive on 10-18, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Cerebral Arteriosclerosis	
Due to	
Other conditions (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?
(Specify type of place)

While at work? (e) Means of injury .....

23. Signature Gordon W Chambers (M. D. or other)

Address Mtn Home, Ark Date signed 10/25/45

1914 (Licensed Embalmer's Statement on Reverse Side) Hoy

RECEIVED
District Health Officer No. 5,
District File Number 1145-426
Date Filed 11-14-45

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 Paige Robertson

Licensed Embalmer No. 3435

P. O. Address .....

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.

S. No. B
25M—45
I 43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 141 Primary Registration District No. ~~3025~~ 5551 Registrar's No. 118

1. PLACE OF DEATH:

(a) County Howell

(b) City or town ("Rural" Howell Twp.)
(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 years, months or days)

In this community 11 mos

2. USUAL RESIDENCE OF DEACESED:

(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 Elijah Hall

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 Sept 29
(Month) (Day) (Year)

8. AGE: Years 69 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace Morgan County Tenn.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 11-6-45 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 8 year 1945 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 — Duration

Due to

Due to

Other conditions
(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

37386