

Health, Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017196

STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 155

1. PLACE OF DEATH a. COUNTY <u>ADAIR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKSVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SHELBYVILLE</u> ¹⁰²⁰ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GRAHAM-SMITH Hosp</u> Length of stay in 1b <u>2 wks</u>		d. STREET ADDRESS <u>SHELBYVILLE MO</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>AARON</u> Last <u>HALL</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>27</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 6, 1873</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>MO MACON COUNTY</u>	
13. FATHER'S NAME <u>ELISHA HALL</u>			14. MOTHER'S MAIDEN NAME <u>SARAH RICKEY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HERMAN HALL RFD MACON MO</u> Address _____	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	331X
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from 4-13-58 to 4-27-58 and last saw ^{her}him alive on 4-27-58
Death occurred at 4:30 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Milton T. Engler M.D.</u> (Degree or title)	22b. ADDRESS <u>Kulcsar, Mo.</u>	22c. DATE SIGNED <u>4-27-58</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-29-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HAZEL DELL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MACON COUNTY MO</u>
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24. FUNERAL DIRECTOR <u>THOMPSON-GREENING SHELBYVILLE MO</u>	25. DATE RECD. BY LOCAL REG. <u>5-7-58</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Pottiff</u>
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(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Charles V. Greening

Licensed Embalmer No. *446*

P. O. Address *Claremont*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (To comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.