JUL 27 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

22368

1. PLACE OF DEATH

County: Ray — Registration District No. 743 — File No. ____
Township: Orrick — Primary Registration District No. 3478 — Registered No. 18
City ____ (No. ____ St. ____ Ward)

2. FULL NAME William A Hall

(a) Residence. No. ____ St., ____ Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	W	Married

5a. If Married, Widowed, or Divorced HUSBAND OF (or) WIFE OF: Serra Hall

6. DATE OF BIRTH (month, day and year): May 7 1841

7. AGE: Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
88	1	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer:

9. BIRTHPLACE (city or town): Orrick
(State or country): Mo

PARENTS

10. NAME OF FATHER: Finney Hall
11. BIRTHPLACE OF FATHER (city or town) ____ (State or country): N Carolina
12. MAIDEN NAME OF MOTHER: Price
13. BIRTHPLACE OF MOTHER (city or town) ____ (State or country): Dont Know

14. INFORMANT: Andy Hall
(Address): Orrick Mo

15. FILED Jn 18, 1929 L E Ellis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (month, day and year): June 17 1929

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 17, 1929, that I last saw h____ alive on June 17, 1929, and that death occurred, on the date stated above, at 10 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of femur
senility

(duration) ____ yrs. ____ mos. 18 ds.

CONTRIBUTORY (SECONDARY): Broncho pneumonia

(duration) ____ yrs. ____ mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —

186A
179B
1018

Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E. R. Williams, M. D.

6/18, 1929 (Address) Orrick, Mo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Riffe	6-19 1929
20. UNDERTAKER	**ADDRESS**
E Thurman	Richmond Mo.

N. B.—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.

89

1
1
2
31

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Ray
Township Orrick
Registration District No. 743
Primary Registration District No. 5-978
File No.
Registered No. 18
City (No. , St. Ward)

2. FULL NAME William A. Hall

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Aug 9, 19 M R. E. Ellis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 1929

17. I HEREBY CERTIFY, That I attended deceased from 19 to , 19
that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture at femur
accidentally
fell to ground
(duration) mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. R. Williams, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

185

13

N. B.—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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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