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

PLACE OF DEATH

County Ray Co Mo

Township ___ or Village ___ or City Richmond Mo (NO. ___ St.; ___ Ward)

Registration District No. 744

Primary Registration District No. 3035

File No. 40449

Registered No. 209

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Richard Hallette

PERSONAL AND STATISTICAL PARTICULARS		
SEX: Male	COLOR OR RACE: White	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
DATE OF BIRTH: Oct 26, 1912 (Month) (Day) (Year)		
AGE: 1 yrs. 2 mos. 4 ds.	If LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work: None		
(b) General nature of industry, business, or establishment in which employed (or employer): None		
BIRTHPLACE (City or town, State or foreign country): Kansas City Mo		
PARENTS — NAME OF FATHER: Richard Hallett		
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo		
MAIDEN NAME OF MOTHER: Annie Wellsomes		
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Randolph Co Mo		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Wellsomes

(ADDRESS) Richmond Mo

Filed Dec 31, 1913. Geo W Hunt Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12 - 31, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 29, 1913, to Dec 31, 1913, that I last saw him alive on Dec 30, 1913, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria

10

(Duration) ___ yrs. ___ mos. few ds.

Contributory (SECONDARY) none

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) E. T. McGaugh M. D.

12-31, 1913 (Address) Richmond

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: City Cemetery

DATE OF BURIAL: Dec 31, 1913

UNDERTAKER: Hunnell & Co

ADDRESS: Richmond Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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CERTIFICATE OF DEATH

PLACE OF DEATH

County ____________

Township ____________ or Village ____________ or City ____________ (NO. ____________ St.; ____________ Ward)

Registration District No. ____________ File No. ____________

Primary Registration District No. ____________ Registered No. ____________

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ____________________________

PERSONAL AND STATISTICAL PARTICULARS

SEX ____ COLOR OR RACE ____ SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) ____

DATE OF BIRTH ____________ (Month) ____ (Day), 1____ (Year)

AGE ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ______ hrs. or ______ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ____________
(b) General nature of industry, business, or establishment in which employed (or employer) ____________

BIRTHPLACE (City or town, State or foreign country) ____________

PARENTS
- NAME OF FATHER ____________
- BIRTHPLACE OF FATHER (City or town, State or foreign country) ____________
- MAIDEN NAME OF MOTHER ____________
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) ____________

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____________

(ADDRESS) ____________

Filed ____________, 191____, ____________ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ____________ (Month) ____ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from ____________, 191____, to ____________, 191____, that I last saw h____ alive on ____________, 191____, and that death occurred, on the date stated above, at ______ m. The CAUSE OF DEATH* was as follows:

____

____

____________________________ (Duration) ______ yrs. ______ mos. ______ ds.

Contributory (SECONDARY) ____________________________ (Duration) ______ yrs. ______ mos. ______ ds.

(Signed) ____________________________ M. D.

____________, 191____ (Address) ____________

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ______ yrs. ______ mos. ______ ds. In the State ______ yrs. ______ mos. ______ ds.

Where was disease contracted if not at place of death? ____________

Former or usual residence ____________

PLACE OF BURIAL OR REMOVAL ____________ DATE OF BURIAL ____________, 191____

UNDERTAKER ____________ ADDRESS ____________