DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40299

DEC 1 1939 REC'D DEC 12

Registration District No. 571 Primary Registration District No. 5769 Registrar's No. 57

1. PLACE OF DEATH:
(a) County Moniteau
(b) City or town Walker Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(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 Mo (b) County Moniteau
(c) City or town Walker T. P.
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Christ Hallering 465
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Anna
6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased Apr (Month) 23 (Day) 1871 (Year)

8. AGE: Years 68 Months 7 Days If less than one day hr. min.

9. Birthplace Moniteau (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name George Hallering
13. Birthplace Germany (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Earl Hallering
(b) Address California Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 25 39 (Month) (Day) (Year)
(c) Place: burial or cremation Monitor Church
18. (a) Signature of funeral director Williams & Friedmyer
(b) Address California Mo
19. (a) 11-24-39 (Date received local registrar) (b) H.R. Popejoy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23
year 1939 hour 9 minute 20 A. M.
21. I hereby certify that I attended the deceased from Nov. 22, 1939, to Nov. 23, 1939, that I last saw him alive on Nov. 22, 1939, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	
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 L. J. O'Bannon (M.D. or other) MD
Address California Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.

I X19511

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. ~~2854~~

working under my personal supervision.

Signed H E Friedmeyer

Licensed Embalmer No. 2854

P. O. Address California M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

o. 2B
-21-40
X22859

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40299

Registration District No. 571 — Primary Registration District No. 5769 — Registrar's No. 57

1. PLACE OF DEATH:
(a) County Montgomery
(b) ~~City or town~~ Walker rural
(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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME 46 Christ Hollering
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 (Month) (Day) (Year)

8. AGE: Years 68 | Months 7 | Days | If less than one day hr. min.

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)
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) 11-24-39 (Date received local registrar) (b) H. R. Pobjoy (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23
year 1939 hour minute M.
21. I hereby certify that I attended the deceased from 19..., to 19...;
that I last saw h... alive on 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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 K. J. O'Bannon (M. D. or other)
Address California Mo. Date signed