

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

Do not use this space.

16601

1. PLACE OF DEATH

County Linn
Township Washington
City (No.) (St.) (Ward)

Registration District No. 464
Primary Registration District No. 5626

File No. 13
Registered No. 15-

2. FULL NAME

Josephine Marie Wakeman

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 25, 1930

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
 20

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) Near Odessa Mo.
(STATE OR COUNTRY) Linn Co. Mo.

10. NAME OF FATHER Herbert Wakeman

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

12. MAIDEN NAME OF MOTHER Beatrice Coneland

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

14. INFORMANT Herbert Wakeman
(Address) Odessa Mo.

15. DATE June 3, 1930 REGISTERED BY R. Schroeder

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15th 1930

17. I HEREBY CERTIFY That I attended deceased from May 9, 1930 to May 14, 1930
that I last saw him alive on May 14, 1930, and that death occurred, on the date stated above, at 4:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia

122B
129 (duration) yrs. mos. da. 2

CONTRIBUTORY Valvular (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? 0/1/1930
IF NOT A PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) R. Schroeder, M. D.
5/16 1930 (Address) Odessa

*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 Mt. Salem Cemetery DATE OF BURIAL 5/16 1930

20. UNDERTAKER L.C. Husman ADDRESS Odessa

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.

JUN 26 1930

