File no.

Registered No. 33

ORIGINAL

STANDARD CERTIFICATE OF DEATH

State Department of Health
Division of Vital Statistics
STATE OF ~~IOWA~~ Missouri

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

V. S. No. 155—Original

1. PLACE OF DEATH
County Worth State ~~IOWA~~ Missouri Registered No. 33
Township Grant or Village 903 35497 or
City ____ No. 1211 St., ____ Ward
(If death occurred in a hospital or institution give its name instead of street and number)
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.

2. FULL NAME Samuel M. Walter
(a) Residence. No. ____ St., ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Walter

6. DATE OF BIRTH (month, day, and year) Jan. 8 1858

7. AGE Years	Months	Days	If less than 1 day, ____ hrs. or ____ min.
74	9	2	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year) ____ 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Iowa Iowa

FATHER
13. NAME Andrew Walter
14. BIRTHPLACE (city or town) (State or country) Not Known Ireland

MOTHER
15. MAIDEN NAME Not Known
16. BIRTHPLACE (city or town) Don't Know

17. INFORMANT Mrs Sarah Walter
(Address) Allendale Mo

18. BURIAL, CREMATION, OR REMOVAL
Place Lots Grove Date Oct 11, 1933

19. LICENSED EMBALMER T. S. Rhodes No. 909
(Address) Pitzer Iowa

20. FILED 10/12, 1933 John Andrews
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) 10/10, 1933

22. I HEREBY CERTIFY, That I attended deceased from April 1st, 1933 to Oct 10, 1933.
I last saw him alive on Oct 5, 1933, death is said to have occurred on the date stated above, at 3 a m.
The principal cause of death and related causes of importance in order of onset were as follows:

	Date of onset
Cerebral Hemorrhage	April 1933
2nd Cerebral Hemorrhage	Oct 3-1933

Contributory causes of importance not related to principal cause: Arterio Sclerosis

Name of operation ____ Date of ____
What test confirmed diagnosis? — Was there an autopsy? ____

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? — Date of injury ____, 19____
Where did injury occur? ____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ____
Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify ____

(Signed) O L Fullerton M. D.
(Address) Redding Iowa

(OVER)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIANS.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY LICENSED EMBALMERS.

Has decedent ever served in military or naval service of the U. S.?..... If so give name of War.....

I, T. S. Rhoades Licensed Embalmer No. 909 hereby certify that the body recorded on the reverse side of this certificate was embalmed by Self L. E. No..... or by..... Registered apprentice No..... working under my personal supervision.

Signed T. S. Rhoades

Licensed Embalmer No.....

NOTE: The above statement MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license).