

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

Do not use this space.

20389-1

AUG 4 1936

1. PLACE OF DEATH

County Monroe Registration District No. 548
Township Levee Primary Registration District No. 5743
City Waldron (No. _____) St. _____ Ward _____

File No. _____
Registered No. 38
St. _____ Ward _____

2. FULL NAME

(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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>S</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May-5-1851</u>		
7. AGE YEARS <u>84</u>	MONTHS <u>2</u>	DAYS <u>2</u>
		If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		
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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 6, 1935

22. I HEREBY CERTIFY, That I attended deceased from June 29, 1935, to July 5, 1935
I last saw him alive on July 5, 1935. Death is said to have occurred on the date stated above at 6:12:30 am.
The principal cause of death and related causes of importance were as follows:

Arterio Sclerotic Heart Disease
Chronic Bronchitis

Other contributory causes of importance:
None

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa

FATHER

13. NAME Frederick Way

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Harriet Sprinkle

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maryland

17. INFORMANT Edna Way (ADDRESS) Waldron Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Stelonia DATE 7-9

19. UNDERTAKER (ADDRESS) E. T. Shrago

20. FILED July 9, 1935 Registrar Waldron Mo

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

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) F. D. Wolfe, M. D.
(Address) Waldron 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.

