

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

Do not use this space
Deering Mo
20263-17

1. PLACE OF DEATH.

County Pemscot Registration District No. 653
Township Briggsville Primary Registration District No. 5871
City Briggsville RFD (No. _____) St. _____ Ward _____

2. FULL NAME Aaron M Waller

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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4/12/1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 1 12

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child
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) Mo

FATHER 13. NAME William Waller

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Delcie Ferrill

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denr

17. INFORMANT William Waller
(ADDRESS) Deering Mo RFD

18. BURIAL, CREMATION, OR REMOVAL
PLACE Maple Cemetery DATE 5/30/36

19. UNDERTAKER H S Smith
(ADDRESS) Caruthersville Mo

20. FILED 6-10-36 J W Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/29, 1936

22. I HEREBY CERTIFY, That I attended deceased from May 15, 1936, to May 29, 1936

I last saw him alive on May 28, 1936 Death is said to have occurred on the date stated above, at 4:10 p. m.

The principal cause of death and related causes of importance were as follows:

Pneumonia Date of onset May 15 1936

Other contributory causes of importance:

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 _____, 1936

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 _____

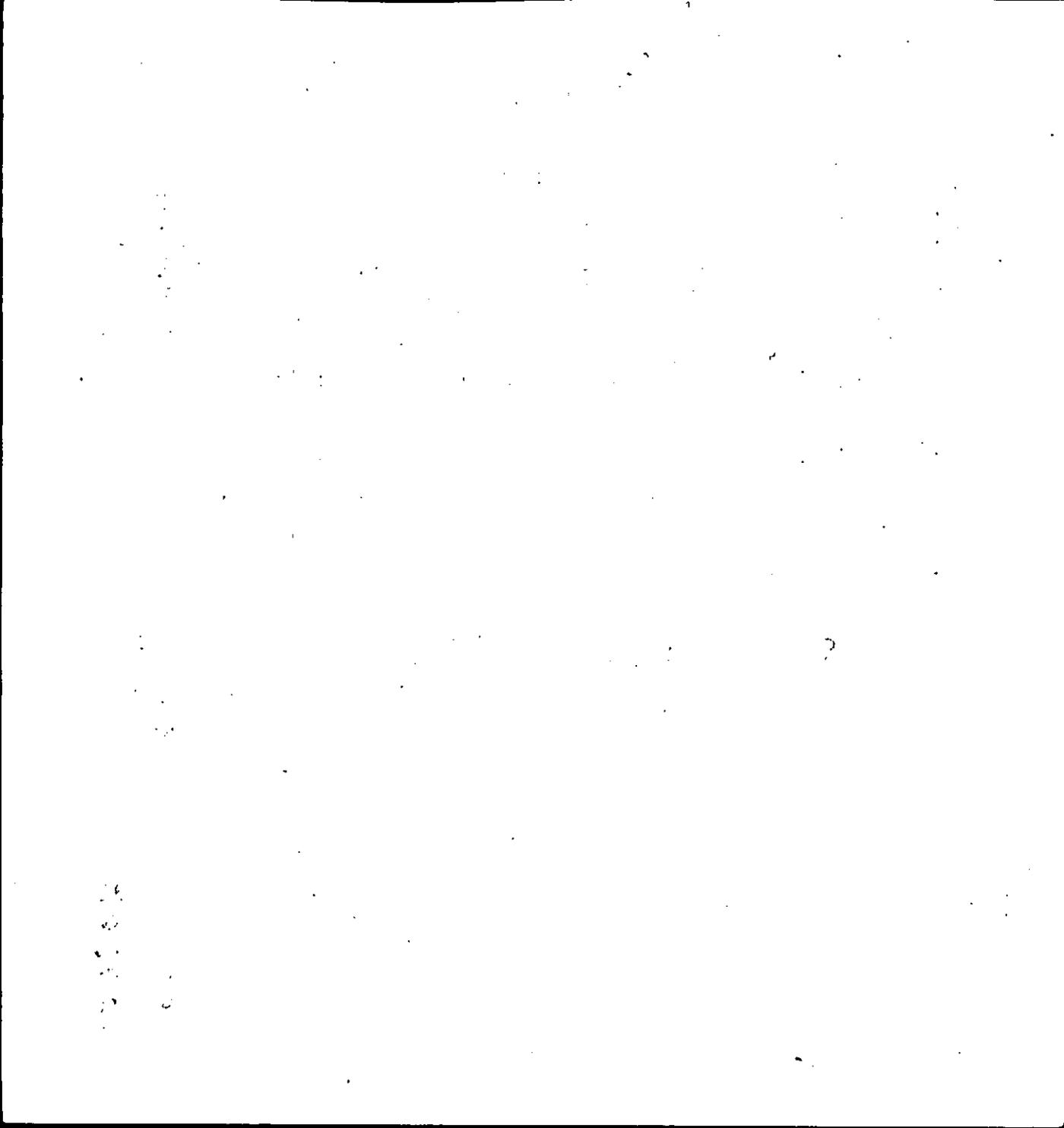
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Wm J. Speer, M. D.

(Address) Deering Mo



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CERTIFICATE OF DEATH**

Do not use this space

*Smith
Jones*

1. PLACE OF DEATH

County Pemiscot
Township Pragadois
City (No.) (St.) (Ward ..)

Registration District No. 653
Primary Registration District No. 3871

File No.
Registered No.

2. FULL NAME

Aaron M. Waller

(a) Residence, No. St. Ward ..
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 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)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>1</u>	<u>1</u>	<u>12</u>	

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

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19...

19. UNDERTAKER (ADDRESS)

20. FILED 9-26 1936 J. W. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/29 1936

22. I HEREBY CERTIFY, That I attended deceased from .., 19.., to .., 19..

I last saw him .. alive on .., 19.. Death is said to have occurred on the date stated above, at .. m.

The principal cause of death and related causes of importance were as follows:

Pneumonia
Bronchial Pneumonia
Date of onset ..
Other contributory causes of importance:
measles

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? ..

If so, specify (Signed) Asert J. Speer, M. D.
(Address) Needing

SUPPLEMENT

3-20263-1

RECEIVED