

REC'D OCT 24 1938

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

32709
Do not use this space.

1. PLACE OF DEATH

(a) County Wagon Registration District No. 940
(b) Township Jackson Primary Registration District No. 5402 Registered No. _____
(c) City Atlanta MO (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Malecin Ellis Waller 460

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 18 64

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 0 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. Housekeeper
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) Wagon Or MO

FATHER 13. NAME Joseph E. Meador

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

MOTHER 15. MAIDEN NAME Sarah A. Arthur

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

17. INFORMANT R. E. Waller (ADDRESS) Atlanta MO

18. BURIAL, CREMATION, OR REMOVAL PLACE McLamb DATE Aug. 31-1938

19. FUNERAL DIRECTOR (NAME) H. M. Gooding (ADDRESS) Atlanta MO

20. FILED Sept 1 1938 J. O. Wall Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 29 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1938, to Aug 29, 1938.
I last saw h. alive on _____, 19____. Death is said to have occurred on the date stated above, at 4:30 am.
The principal cause of death and related causes of importance were as follows:

Acute Myocarditis
Date of onset Aug 29 38
Other contributory causes of importance: _____

Name of operation none Date of _____
What test confirmed diagnosis? Obtained 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. at home
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify _____ (Signed) Bo West Abner M. D.
480 (Address) New Cambria MO

RECORDED
DISTRICT HEALTH OFFICER
10-38-288
10-8-38

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,

H. M. Gooding

or by

Registered Apprentice No., working under my personal supervision.

Signed

H. M. Gooding

Licensed Embalmer No. 1750.

P. O. Address

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

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