

REC'D OCT 21 1938

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

33201  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 773  
 (b) Township St. Francois Primary Registration District No. 6018A  
 (c) City Farmington (d) Street No. State Hospital No 4 Registered No. 126  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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 Wilhelmina Walsh

(a) Residence, No. Salem, Mo. 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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 8th 1938

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

22. I HEREBY CERTIFY, That I attended deceased from 8-20-37, 19....., to 10-8-38, 19.....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ?  
 7. AGE YEARS 53 MONTHS ? DAYS ? If LESS than 1 day, ..... hrs. or ..... min.

I last saw h. alive on 10-7-38, 19..... Death is said to have occurred on the date stated above, at 12:50 pm

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

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.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

Right lobe pneumonia Date of onset 10-7-38  
with terminal  
acute nephritis 2 da

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

Other contributory causes of importance:  
Chronic Valvular heart dis.  
Cholesterolemia  
Arteriosclerosis  
Arterio-sclerosis  
Arterio-sclerosis  
 Name of operation None Date of None  
 What test confirmed diagnosis None Was there an autopsy? No

FATHER 13. NAME Unknown  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vermont

MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? None Date of injury None, 19.....  
 Where did injury occur? None (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT State Hospital #4 Records (ADDRESS) Farmington, Mo.

Manner of injury  
 Nature of injury

18. BURIAL, CREMATION, OR REMOVAL PLACE Springfield, Mo. DATE 10-10-1938

24. Was disease or injury in any way related to occupation of deceased Yes  
 If so, specify None  
 (Signed) J. H. Robinson M.D.  
 (Address) Farmington, Mo.

19. FUNERAL DIRECTOR (NAME) Weidert's Undertaking Co. (ADDRESS) Farmington, Mo.  
and Null and Sons  
Rolla, Missouri

20. FILED Oct 8-1938 J. H. Robinson Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY.

**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, .....

*C J Floyd*

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed *Assistant Inval C*  
*C J Floyd*

Licensed Embalmer No. *3527*

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.**