

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.

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

10945
Do not use this space.

1. PLACE OF DEATH

(a) County Henry Registration District No. 347
(b) Township 4 Primary Registration District No. 4210
(c) City Quick (d) Street No. _____
(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. 6 mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Walker Davidson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>2-28-1858</u>		
7. AGE	YEARS <u>81</u>	MONTHS <u>0</u>
	DAY <u>13</u>	IF LESS THAN 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	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 <u>Life</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Quincy Ill</u>		
FATHER	13. NAME <u>Joseph Maltley</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>	
MOTHER	15. MAIDEN NAME <u>Jane Walker</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>	
17. INFORMANT (ADDRESS) <u>Blanch McMahon Quick Mrs</u>		
18. BURIAL, CREMATION OR REMOVAL PLACE <u>Garden City</u> DATE <u>3-13-1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Fred C. Wilkinson</u> <u>Christy Mrs</u>		
20. FILED <u>3-20-1939</u> <u>Dr J. B. Hampton</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 12 1939
22. I HEREBY CERTIFY, That I attended deceased from Mar 12 1939 to Mar 12 1939
I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at 9:00 p.m.
The principal cause of death and related causes of importance were as follows:

Angina Pectoris

Other contributory causes of importance: 94 W

Name of operation X 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? no Date of injury _____, 19____
Where did injury occur? Y (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Y
Nature of injury Y

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) J. W. Galbreath, M. D.
(Address) Quick Mrs

RECEIVED

District Health Officer No. 7,

District File Number 7-39-664

Date Filed 4-17-39

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, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2478

P. O. Address Clinton, Mo.

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.