

1939 AUG 10 1939

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

25152
Do not use this space.

1. PLACE OF DEATH *Butter* 2
 (a) County *Butter* Registration District No. *89*
 (b) Township *1* Primary Registration District No. *3007*
 (c) City *Poplar Bluff* (d) Street No. _____ St.
 (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.
460 Donald Carl Waller

2. PRINT FULL NAME *Donald Carl Waller*
 (a) Residence, No. *Fremont Mo. Carter Co. Mo.* 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 *Male* 4. COLOR OR RACE *White* 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) *Nov 26, 1936*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>2</i>	<i>7</i>	<i>10</i>	

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.

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) *Carter Co Mo.*

FATHER

13. NAME *Donald Maurice Waller*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Stoddard Co. Mo.*

MOTHER

15. MAIDEN NAME *Dora Irene Stinnette*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Carter Co Mo.*

17. INFORMANT *Donald M Waller* (ADDRESS) *Fremont Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Fremont Mo* DATE *7/7 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *none*

20. FILED *7/6 1939* *Chambers* Local Registrar. *89*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-6 1939*

22. I HEREBY CERTIFY, That I attended deceased from *June 28 1939*, to *July 6 1939*
 I last saw him alive on *July 6 1939*. Death is said to have occurred on the date stated above, at *9 A. m.*
 The principal cause of death and related causes of importance were as follows:
Acute Colitis with diarrhea Date of onset *6-22-39*

Other contributory causes of importance:
Chol. media *7-1-39*

Name of operation *Peritonitis* - Date of *7-3-39*
 What test confirmed diagnosis? *Chromal* 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) *W. B. Brackner* M. D.
 (Address) *Poplar Bluff 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.

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.....

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.