

36 AUG 11 1939

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

26597  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Putnam 7 Registration District No. 720  
 (b) Township Grant 1 Primary Registration District No. 6234  
 (c) City or (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. 10 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Mary J. Walters*  
 (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 OF RACE *White*  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) *Widowed*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Joseph P. Walters*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 18-1884*  
 7. AGE YEARS *55* MONTHS *-* DAYS *9* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Home work*  
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 15 1939*  
 22. I HEREBY CERTIFY That I attended deceased from *July 12 1939* to *July 15 1939*  
 I last saw him alive on *July 15 1939*. Death is said to have occurred on the date stated above, at *10:30 A.M.*  
 The principal cause of death and related causes of importance were as follows:  
*Epilepsy*  
 Date of onset  
 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 \_\_\_\_\_, 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) *P. V. West* \_\_\_\_\_, M. D.  
 (Address) *Coatesville, Mo.*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Lee Co. Iowa*  
 FATHER  
 13. NAME *Henry Clay Dean*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Penn*  
 MOTHER  
 15. MAIDEN NAME *Christena Hagler*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Virginia*  
 17. INFORMANT (ADDRESS) *Joe Walters Coatesville, Mo.*  
 18. BURIAL, CREMATION OR REMOVAL PLACE *Bratcher Co. Mo.* DATE *July 20 1939*  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *F. O. ... Amosville, Mo.*  
 20. FILED *Aug 1 1939 E. E. McCallister 647* Local Registrar

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED

District Health Officer No. 10

District File Number 8-139-1354

Date Filed AUG 5 1939

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 Murl E. Husted

Licensed Embalmer No. 3304

P. O. Address Unionville, N.C.

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.