

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

33695
Do not use this space.

1. PLACE OF DEATH
 (a) County Stoddard Registration District No. 238
 (b) Township Dexter Primary Registration District No. 45076098B Registered No. _____
 (c) City _____ (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.

2. PRINT FULL NAME Marcella Louise Walker
 (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 (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 22, 1934

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	4	11	8	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
 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) Stoddard Co., Mo.

FATHER 13. NAME LeRoy Walker
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Co., Mo.

MOTHER 15. MAIDEN NAME Agnes Arnold
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Co., Mo.

17. INFORMANT LeRoy Walker
 (ADDRESS) Essex, Mo. Rfd.

18. BURIAL, CREMATION, OR REMOVAL PLACE Old Bethel Cem DATE Oct. 1/39,
Blankenship-Strickland

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dexter, Mo.

20. FILED 10/9 1939 Jennie Burbon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1939, to Sept 30, 1939
 I last saw him alive on Sept 30, 1939 Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Rabies
 Date of onset Sept 15

Other contributory causes of importance: 2.1

Name of operation _____ Date of _____
 What test confirmed diagnosis? Chemical 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 _____
 Where did injury occur? Dog bite about Sept 9
 (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? _____
 If so, specify _____
 (Signed) George Schaefer, M. D.
 (Address) Dexter 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.

RECEIVED

District Health Officer No. 2

District File Number 1039-267

Date Filed 10-11

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.