

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

35337

Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
(b) Township _____ Primary Registration District No. 3001 Registered No. 252
(c) City Kirksville (d) Street No. Grim-Smith Hospital 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 Mrs. Allie Waddill

(a) Residence, No. Yarrow, 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

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 1, 1912

7. AGE YEARS 27 MONTHS 6 DAYS 11 IF LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmwife

9. Industry or business in which work was done, as saw mill, bank, etc. Agriculture

10. Date deceased last worked at this occupation (month and year) Sept 5, 1939 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adair County Mo.

13. NAME D. R. Payton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howell County Mo.

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Gail Waddill Yarrow, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Temple DATE 10/14/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Davis Funeral Home Kirksville, Mo.

20. FILED Oct 19 1939 Spencer L. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1939, Oct 12, 1939

I last saw her alive on Oct 12, 1939 Death is said to have occurred on the date stated above, at 2:30 p.m.

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

Septicemia - Endometritis and pelvic peritonitis.

Date of onset Sept 23, 1939

Other contributory causes of importance: Childbirth - about 2 weeks prior to onset of septicemia.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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 Spencer L. Freeman M. D.

(Signed) Spencer L. Freeman (Address) Kirksville, Mo.

RECEIVED

District Health Officer No. 10

District File Number 11-39-2016

Date Filed NOV 15 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.....

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.