

WHILE PLAINLY UNFADING BLACK INK—MAKE 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.

Registration District No. 1839

Primary Registration District No. 5010

Registrar's No. 273

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Rural
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Life
years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Ethel May Walters
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Willie Walters 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased September 5 1895
(Month) (Day) (Year)

8. AGE: Years 44 Months 2 Days 8
If less than one day _____ hr. _____ min.

9. Birthplace Novinger Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Housewife

MOTHER FATHER
12. Name George Chesser
18. Birthplace Lawrence Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Mary Price
15. Birthplace Milan Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Chesser
(b) Address Novinger Mo

17. (a) Burial (b) Date thereof Nov 15 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle, Mo.

18. (a) Signature of funeral director Glenn E. Kent & Son
(b) Address Green City, Missouri

19. (a) Nov. 16/39 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Near Stahl
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13
year 1939 hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from Nov 12
1939, to Nov 13 1939
that I last saw her alive on Nov 13 1939
and that death occurred on the date and hour stated above.

Immediate cause of death congestive heart failure
Chronic endocarditis & myocarditis
Due to anguluzia
Due to debility from nursing & old heart lesion
Other conditions _____
(Include pregnancy within 8 months of death)

Duration _____
20 1/2

Major findings: _____
Of operations none
Of autopsy none

PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. Gaskwiler (M. D. certifier)
Address Novinger Mo Date signed 11/14/39

RECEIVED

District Health Officer No. 10

District File Number 12-39-2189

Date Filed DEC 11 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 Glenn E. Reut

Licensed Embalmer No. 1769

P. O. Address Green City 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.