

WRITE PLAINLY—USE 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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

DEC 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39246

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 134

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town Carrollton
 (c) Name of hospital or institution: Scovern Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community _____ years, months or days 1125

3. (a) PRINT FULL NAME Myrtle Ann Walden

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thos G Walden 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Apr 27 1910
 (Month) (Day) (Year)

8. AGE: Years 29 Months 6 Days 9 If less than one day _____

9. Birthplace Carroll Co Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation House-wife

11. Industry or business _____

12. Name Samuel L Rader

13. Birthplace Kentucky
 (City, town, or county) (State or foreign country)

14. Maiden name Ida May Green

15. Birthplace Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Samuel L Rader

(b) Address Marshall Mo

17. (a) Burial (b) Date thereof 11-8-1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation De Witt Mo

18. (a) Signature of funeral director Milton Standley

(b) Address Carrollton Mo

19. (a) 11-6-1939 (b) John Haskins
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
 (c) City or town Miami Station
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5 year 1939 hour 6 minute 15 M.

21. I hereby certify that I attended the deceased from 11/3/39 to 11/5/39, 19____; that I last saw her alive on 11/5/39, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes

Due to _____
 Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (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 A. D. Drown (M. D. or other) M.D.
 Address Carrollton Mo Date signed 11/6/39

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12/6/39

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address. Carrollton, W

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.