

Registration District No. 91

Primary Registration District No. 6039

Registrar's No. 191

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Waverly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saline County Home 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year
(Specify whether years, months or days)
In this community 25 years

3. (a) PRINT FULL NAME Marion Madeline Walker

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased: March 10 1872
(Month) (Day) (Year)

8. AGE: Years 67 Months 8 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name William M Walker

13. Birthplace Laclede Co Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Lizzie Vestal

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

16. (a) Informant's own signature Mayfont Wallace

(b) Address 558 West Morgan

17. (a) Burial (b) Date thereof Nov 22-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park Cem

18. (a) Signature of funeral director Campbell Harris

(b) Address Marshall Mo

19. (a) 11-22-39 (b) Mary Kent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline
(c) City or town _____
(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 20
year 1939 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov 1
1939, to Nov 19, 1939;
that I last saw him alive on Nov 18, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Thyroid carcinoma & decomposition
Duration 7

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy _____
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) _____
(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? _____

23. Signature Marshall (M. D. or other) ✓
Address Marshall Date signed 11/21/39
While at work (Specify type of place) (e) Means of injury _____

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.

1 X1931

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12/20/39

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.....

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.

o. 2B
10
2559

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 796

Primary Registration District No. 6039

Registrar's No. _____

1. PLACE OF DEATH

(a) County Saline
(b) City or town Marshall rural
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME MARION MADISON DECKER

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 67 Months 8 Days 7 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 3-22-40

19. (a) 3-22-40 (b) Mary Kent
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20
year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

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 Robert C. Hayner (M. D. or other) _____

Address Marshall Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

