No. 2
21-10

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 22 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10808

Registration District No. 259 Primary Registration District No. 4158 Registrar's No.

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

1. PLACE OF DEATH: (a) County: DeKalb
(b) City or town: Maysville Mo
(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 years, months or days)
In this community 55 years

2. USUAL RESIDENCE OF DECEASED: (a) State Mo (b) County DeKalb
(c) City or town Maysville Mo.
(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.

3. (a) PRINT FULL NAME Alonzo Glenn Wait
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Juritta Wait
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased 9 (Month) 6 (Day) 1870 (Year)

8. AGE: Years 69 Months 6 Days 17 If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country)
10. Usual occupation Merchant
11. Industry or business Grocery & Meat
FATHER 12. Name Olin Wait
13. Birthplace (City, town, or county) Ohio (State or foreign country)
MOTHER 14. Maiden name Elizabeth Higgins
15. Birthplace (City, town, or county) Ohio (State or foreign country)
16. (a) Informant Ernest Wait
(b) Address Maysville Mo
17. (a) Fairport Mo (Burial, cremation, or removal) (b) Date thereof 3 20 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Fairport Mo
18. (a) Signature of funeral director Hudson Bryan
(b) Address St Joseph Mo
19. (a) 3-20-40 (Date received local registrar) (b) Ethel H Power (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 18 year 1940 hour 2:58 minute P. M.
21. I hereby certify that I attended the deceased from FEB. 4, 1940 to MAR. 18, 1940 that I last saw him alive on MAR. 18, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	3-17-40
Due to: Generalized Anasarca	Sept. 1939
Due to: Chronic Bright's Disease	undet
Chronic Myocarditis with failure	
Other conditions (Include pregnancy within 3 months of death): Generalized arteriosclerosis	undet.
with hypertension; secondary anemia	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature John M. Cooper M.D. (M. D. or other)
Address 234 MAYSVILLE, MO Date signed 3-19-40

(Licensed Embalmer's Statement on Reverse Side)

181

RECEIVED
District Health Officer No. 11,
District File Number 440-490
Date Filed APR 10 1940

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 W. M. E. Summerfield

Licensed Embalmer, No. 3007

P. O. Address 319 So. 10 St. Joseph 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.

S. No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10808

Registration District No. 259 Primary Registration District No. 4158 Registrar's No.

1. PLACE OF DEATH:
(a) County DeKalb
(b) City or town Maryville
(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 years, months or days)
In this community

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)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Alonzo Glenn Waite
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 M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 12 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 18 year 1940 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 Hypostatic Pneumonia (LOBAR) — Duration 10 d
Due to Generalized Anasarca
Due to Chronic Bright's Disease
Other conditions (Include pregnancy within 3 months of death) Chronic Cardiac with failure, Generalized Arteriosclerosis with Hypertension, secondary anemia
Major surgical operations
Or 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature John M. Cooper (M. D. or other)
Address Maryville Mo. Date signed

SUPPLEMENTARY

S-10808
1940