

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

14735
Do not use this space.

1. PLACE OF DEATH

(a) County Crawford Co Registration District No. 232
 (b) Township Porter's Primary Registration District No. 5316
 (c) City _____ (d) Street No. _____ 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. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
George Washington Waller
Crawford Co
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Jane Bruckey

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 23-1856

7. AGE YEARS 83 MONTHS 4 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. None
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford Co Mo

FATHER 13. NAME Thomas Waller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ills. 1

MOTHER 15. MAIDEN NAME Galitha Trask

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____ 9

17. INFORMANT (ADDRESS) Same Kinnowitz
Shelville Mo

18. BURIAL, CREMATION OR REMOVAL PLACE Waller Cemetery DATE 3/28-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ed Jones
Shelville Mo

20. FILED April 16, 1940 - J. E. Sanders
Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/26-1940

22. I HEREBY CERTIFY, That I attended deceased from 1-1, 1940, to 3-26, 1940

I last saw him alive on 3-20, 1940 Death is said to have occurred on the date stated above, at 29 a.m.
 The principal cause of death and related causes of importance were as follows:

Influenza
 Date of onset _____
 Other contributory causes of importance: Age

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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?
 If so, specify _____
 (Signed) H. C. Parker, M. D.
Shelville Mo
 (Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

L. J. Janas

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED
RECEIVED

District Health Officer No. 5,
District Health Officer No. 5,

File Number.....
District File Number *540 546*

Date Filed *5-12-40*

Signed *L. J. Janas*

Licensed Embalmer No. *2879*

P. O. Address *Stulville St*

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.