

Registration District No. 305

Primary Registration District No. 4184

Registrar's No. 11

1. PLACE OF DEATH:

(a) County GASCONADE
(b) City or town OWENSVILLE
(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 20 YRS. _____ (Specify whether
years, months or days) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE
(c) City or town OWENSVILLE
(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 PHOEBE ELLON WALLS

8. (b) If veteran, name was NONE 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife LUTHER WALLS 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased FEB. 26 1886
(Month) (Day) (Year)

8. AGE: Years 55 Months 2 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace OAK HILL MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK
11. Industry or business OWN HOME

12. Name ED. McCANN
13. Birthplace WASHINGTON MISSOURI
(City, town, or county) (State or foreign country)
14. Maiden name ANN NAUGLE
15. Birthplace OAK HILL MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant Rozell B. Joquith
(b) Address _____

17. (a) BURIAL (b) Date thereof APRIL 29 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation OWENSVILLE CITY CEM.

18. (a) Signature of funeral director W.F. Gattenbacher
(b) Address OWENSVILLE Mo

19. (a) 4-30-40 (b) Stah A. Barnes MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 27
year 1940 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from 4-10
_____ 1940 to 4-27 1940;
that I last saw her alive on 4-27 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypostatic Pneumonia Duration 3 days
Due to Myocardial Insufficiency 2 wks.
--- Chronic Myocarditis 2 yrs.
Due to Arteriosclerosis 5 yrs.
Other conditions Asthma 20 yrs.
(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? 929

(Specify type of place) _____
While at work? Paul A. Branch (e) Means of injury _____
23. Signature Paul A. Branch (M. D. or other) MD
Address Owensville Date signed 4-29-40

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

92C

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 Melford H. H. Winter
Licensed Embalmer No. 3838

P. O. Address Owensville 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1485-0**
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **305-**

Primary Registration District No. **4184**

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

1. PLACE OF DEATH:

(a) County **Gasconade**

(b) City or town **Owensville**
(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 _____
In this community _____ (Specify whether 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)

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

3. (a) PRINT FULL NAME **Phoebe Ellen Walls**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **apr** day **27**
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.

4. Sex **7**

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) _____

Immediate cause of death **Hypostatic pneumonia, lobar**

Due to **myocardial insufficiency**

Due to **arteriosclerosis**

8. AGE: Years Months Days If less than one day

55 **2** **1** _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) **108**

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

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 **Paul H. Branner** (M. D. or other) _____

Address **Owensville Mo** Date signed _____

SUPPLEMENTARY

S-14850