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21492

State File No. _____

Registration District No. 1039

Primary Registration District No. 5010

Registrar's No. 105

1. PLACE OF DEATH:

(a) County Adair Morrow
(b) City or town Stahl (Rural)
(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 2
In this community Five Times (Specify whether years, months or days)

3. (a) PRINT FULL NAME JONAH MALCUM WALTERS
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 Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 29 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 10 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Lewis Walters
13. Birthplace Linn (City, town, or county) (State or foreign country)
14. Maiden name Rachel Cook
15. Birthplace Ind (City, town, or county) (State or foreign country)

16. (a) Informant George Walter
(b) Address Woringer

17. (a) Burial (b) Date thereof May 11/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation McBrew

18. (a) Signature of funeral director Sumner & Pugh
(b) Address Kirkville Mo

19. (a) 5/13/40 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Adair
(c) City or town Near Stahl (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 May day about 9th
year not date known hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Read on my annual 19 _____
that I last saw him alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to arterio sclerosis
Due to _____
Other conditions (Include pregnancy within 3 months of death) g2u
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature L. D. Davis (M. D. or other) MD
Address Kirkville, Mo. Date signed 5-13-40

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

RECEIVED

District Health Officer No. 10

District File Number 6-40-1257

Date Filed JUN 13 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.....

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.