No. 2
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FILED AUG 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24679

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 804

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Saint Joseph, (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital, (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Months (Specify whether
In this community 60 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri, (b) County Buchanan
(c) City or town Saint Joseph, (If outside city or town limits, write "RURAL")
(d) Street No. 731 No. 25th. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Loren W. Walling, 452
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 Widowed,
6. (b) Name of husband or wife Susan Walling. 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased October 10th. 1860 (Month) (Day) (Year)

8. AGE: Years 79 Months 9 Days 15 If less than one day ____ hr. ____ min.

9. Birthplace Agency, (City, town, or county) Missouri, (State or foreign country) 6
10. Usual occupation Engineer, 9
11. Industry or business Railroad, 9
FATHER
12. Name Crowell Walling,
13. Birthplace Unknown, (City, town, or county) Unknown, (State or foreign country)
MOTHER
14. Maiden name Margaret Stanton,
15. Birthplace Unknown, (City, town, or county) Unknown, (State or foreign country)
16. (a) Informant Leocadia McGinnis
(b) Address 731 N. 25th. Street,
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Mora Cemetery,
18. (a) Signature of funeral director Heaton - Bergole - Bowman Funeral
(b) Address 319 S. 10th. Street, Home
19. (a) 7-26-40 (Date received local registrar) (b) A. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25th. year 1940 hour 10:00 minute 15 a M.
21. I hereby certify that I attended the deceased from Mar 4, 1940 to July 25, 1940
that I last saw him alive on July 24, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

Duration

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) Had hip fracture Mar 4
(b) Date of occurrence Mar 4 - 1940
(c) Where did injury occur? At home (City or town) St. Joseph Mo (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home (Specify type of place)
While at work? — (e) Means of injury — FALL
23. Signature L. H. Tuson (M. D. or other) MD
Address St. Joseph Mo Date signed 7-26-40

(Licensed Embalmer's Statement on Reverse Side)

JUN 20 1941

APR 15 1953

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 July 25 ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Wm E. Summerville

Licensed Embalmer No. 3007

P. O. Address 319 Soo St Paul

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.