

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32520

State File No. _____

FILED OCT 18 1940

Registration District No. 546

Primary Registration District No. 5735

Registrar's No. 14

1. PLACE OF DEATH:

(a) County W. Marie
(b) City or town W. Marie
(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 2
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Mary Ann Waldron
3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex 3 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mark Waldron 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 3 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 10 23 hr. _____ min.

9. Birthplace W. Marie Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

12. Name Dennie Hart
13. Birthplace Va
(City, town, or county) (State or foreign country)
14. Maiden name Jane Moreland
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Charley Waldron

(b) Address W. Marie

17. (a) Burial (b) Date thereof 9-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Springs Cem

18. (a) Signature of funeral director W. J. Edson

(b) Address W. Marie

19. (a) 12-1940 (b) Sam A. Warner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County W. Marie
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. W. Marie
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11
year 1940 hour _____ minute 30 A. M.

21. I hereby certify that I attended the deceased from Aug 1
_____, 1940, to 9-11-40, 1940
that I last saw him alive on Aug 10
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Duration _____

Due to seizure

Due to _____

Other conditions none
(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? 485

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature E. E. F. Smith M. D. or other! _____

Address W. Marie Date signed 9-12-40

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

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. 3397

P. O. Address Rella 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.