

JAN 25 1941
Registration District No. 233

Primary Registration District No. 5312

Registrar's No. 345

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Leasburg 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 _____
(Specify whether
In this community 59 1/2 mo 28 d
years, months or days) 2

3. (a) PRINT FULL NAME URIAH JEFFERSON WALLS

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 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 Oct. - 21 - 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Henry R Walls

13. Birthplace Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Brenda

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

16. (a) Informant G. E. Walls

(b) Address Leasburg #1 Mo.

17. (a) Burial (b) Date thereof 12-21-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leasburg

18. (a) Signature of funeral director Albert E. ...

(b) Address BAURBON, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford
(c) City or town Leasburg Rural
(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 Dec day 19th
year 1940: hour 2 minute 10 A M.

21. I hereby certify that I attended the deceased from Sept 2
1940 to Dec 17 1940
that I last saw him alive on Dec 17 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of the Lungs
Duration 2 yrs

Other conditions (Include pregnancy within 3 months of death) Fr

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? _____

23. Signature D. F. Sturm (M. D. or other) 1
Address Leasburg Mo. Date signed 12-20-40

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

MOTHER FATHER

RECEIVED

District Health Officer No 5,

District File Number.

14/93

Date Filed

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

Elbert Long

Licensed Embalmer No.

6504

P. O. Address

Courton, 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42292

Registration District No. 233

Primary Registration District No. 5313

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Leasburg
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Viriah Jefferson Walls

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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)

8. AGE: Years 59 Months 1 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec. 21 (b) W. F. Drumm, M.D.
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19
year 1946 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.

Immediate cause of death _____
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) _____
(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 W. F. Drumm (M. D. or other) _____
Address Leasburg, Mo. Date signed _____

SUPPLEMENTARY

