

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

3546
Do not use this space.

1. PLACE OF DEATH
 (a) County New Madrid Registration District No. 5-0
 (b) Township Gideon Primary Registration District No. 6262
 (c) City Gideon (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME Bklyn Alvert ~~Watts~~ Wallis 72
 (a) Residence, No. Gideon Mo (If death occurred in Hospital or Institution, write its name instead of street and number)
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 17 1941
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 10
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. infant
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 27 1941
 22. I HEREBY CERTIFY, That I attended deceased from Jan 17 1941, to Jan 27 1941
 I last saw him alive on Jan 25 1941 Death is said to have occurred on the date stated above, at 10:30 am
 The principal cause of death and related causes of importance were as follows:

Parainfluenza failed to close

Date of onset

Other contributory causes of importance: 157

Name of operation none Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 19____
 Where did injury occur? none (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none
 Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Bob Evers, M. D.
 (Address) Gideon Mo

12. BIRTHPLACE (CITY OR TOWN) Gideon Mo (STATE OR COUNTRY) Mo
 FATHER 13. NAME Jack Wallis
 14. BIRTHPLACE (CITY OR TOWN) Okla (STATE OR COUNTRY) Okla
 MOTHER 15. MAIDEN NAME Zula Horner
 16. BIRTHPLACE (CITY OR TOWN) Gideon Mo (STATE OR COUNTRY) Mo
 17. INFORMANT Jack Wallis (ADDRESS) Gideon Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Shoemake DATE Jan 27 1941
 19. FUNERAL DIRECTOR Linda (ADDRESS) Campbell Mo
 20. FILED 2-17 1941 Elizabeth Mumma Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important!

WHITE-CORNETT, WITH IMPROVING IMPRESSIONS—THIS IS A PERMANENT RECORD

1 X1204

RECEIVED

District Health Officer No. 2

District File Number 241-281

Date Filed 2/19/41

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

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.)