

JAN 16 1942

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

Do not use this space.

42716

1. PLACE OF DEATH

County Phelps
Township Walla
City Walla

Registration District No. 677
Primary Registration District No. 4403
(No. W. H. H. Hospital)

File No. 170
Registered No. 170
St. Walla Ward 2

2. FULL NAME Cleo Irene Falls

(a) Residence, No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
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 UNKNOWN

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-5-1941

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
19 3

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Satania Kans

13. NAME R. E. Falls

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oklahoma

15. MAIDEN NAME Mildred Porter

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oklahoma

17. INFORMANT R. E. Falls
(ADDRESS) Dixon - Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Dixon MO. DATE 12/20/41

19. UNDERTAKER Fred H Gilbert
(ADDRESS) Dixon - Mo.

20. FILED 1220 1941 Joe F. Coyle Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 18, 1941

22. I HEREBY CERTIFY, That I attended deceased from Dec 13 1941, to Dec 18, 1941
I last saw h. p. alive on Dec 18, 1941. Death is said to have occurred on the date stated above, at 11 P.m.

The principal cause of death and related causes of importance were as follows:
Inflammation of the
coronary segment of the

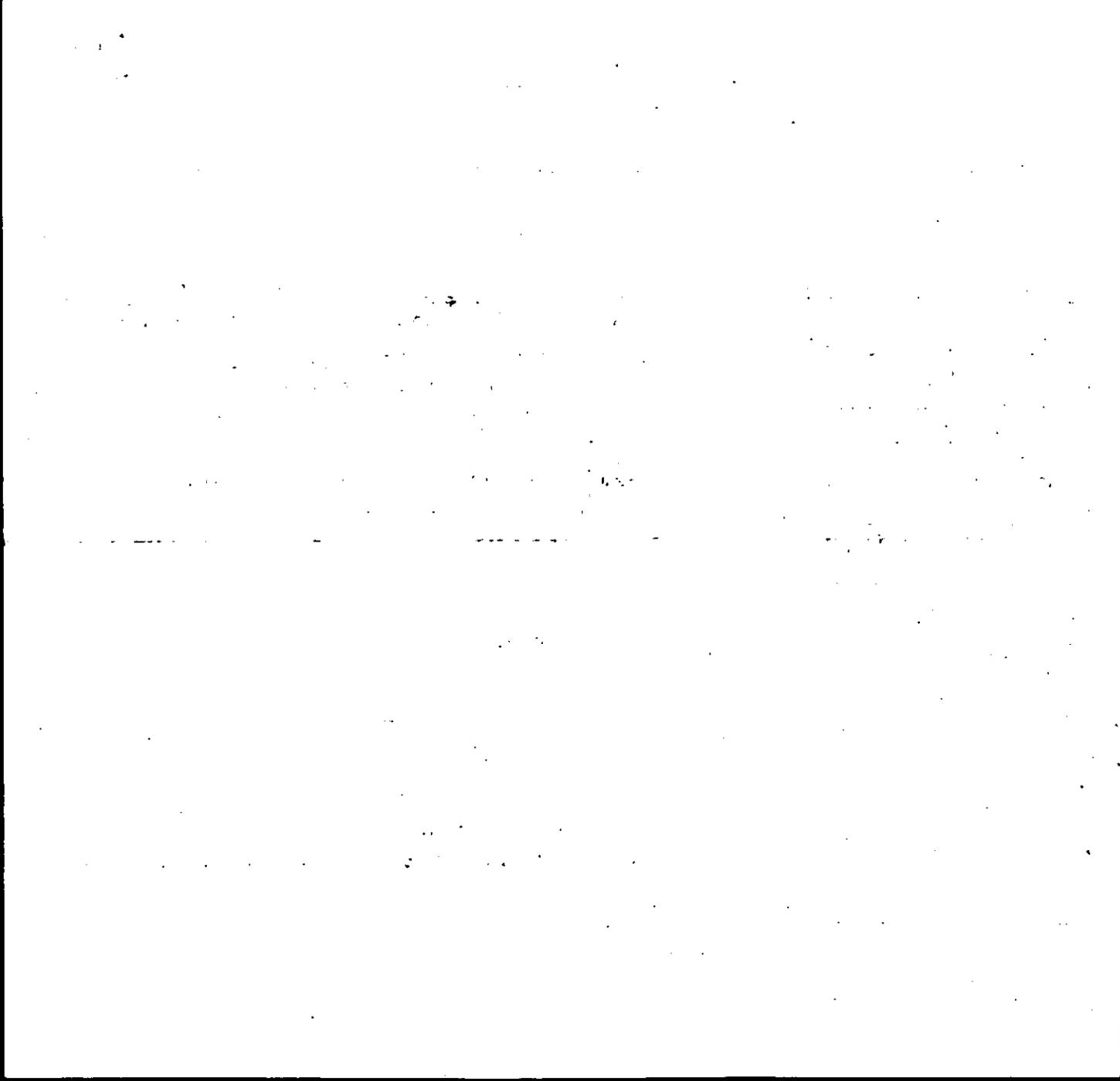
Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) W. H. H. Hospital M. D.
(Address) Walla Mo.



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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42716

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. _____

1. PLACE OF DEATH Phelps
 (a) County Phelps
 (b) City or town Ballal
 (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 _____ years, months or days)

3. (a) PRINT FULL NAME Cleo D. Falls
 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 S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 5 1941
 (Month) (Day) (Year)

8. AGE: Years 19 Months - Days 14 (If less than one day, in 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 _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
 (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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
 year 1941 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____;
 _____ 19____;
 that I last saw him _____ live on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Inflammation of the lower segment of uterus
 Due to could not determine cause of inflammation
 Due to possibly self inflicted
 Other conditions we could get no history of any cause
 (Include pregnancy within 3 months of death) Abortion
 Major findings: could not determine whether it was self induced or criminal
 Of operations _____
 Of autopsy 141e

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

23. Signature [Signature] (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

S-42716