S No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 11 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42289

Registration District No. 374 Primary Registration District No. 6273 Registrar's No.

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

1. PLACE OF DEATH:
(a) County North County
(b) City or town Blockton Iowa Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 13 Lotchin Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community 16 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County North
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Blockton Iowa Rural
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ANGILINE MARIE WALL
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
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 Sept (Month) 14 (Day) 1941 (Year)

8. AGE: Years 1 Months 3 Days 15 If less than one day hr. min.

9. Birthplace Blockton (City, town, or county) Iowa (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name Duane Wall
13. Birthplace Grant City (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name Letha Shemill
15. Birthplace Denver (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Duane Wall
(b) Address Blockton Iowa
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21-42 (Month) (Day) (Year)
(c) Place: burial or cremation Honey Grove Cemetery
18. (a) Signature of funeral director Arch C Dunlap
(b) Address Grant City Mo.
19. (a) Dec 21-1942 (Date received local registrar) (b) Estefa Scadden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1942 hour 1 minute 45 A.M. 9

21. I hereby certify that I attended the deceased from Dec 18 1942, to Dec 19 1942, that I last saw her alive on Dec 18 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Bronchial) — Duration 3 days

Due to

Due to

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

23. Signature [illegible] M.D. (M. D. or other)
Address Date signed 1/11/42

11 04 (Licensed Embalmer's Statement on Reverse Side)

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 Arch C. Dunlee

Licensed Embalmer No. 3252

P. O. Address Grant City 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, fact should be so stated above.

. S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42289

Registration District No. 374 Primary Registration District No. 6273 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Rural
(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)

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

3. (a) PRINT FULL NAME Angeline M. Wall

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 Sept (Month) 4 (Day) 1941 (Year)

8. AGE: Years 1 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Iowa (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)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19
year 1942 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 Pneumonia Bronchial — Duration 3 days

Due to followed severe cold —

Due to I saw this child only once 3 hour before death —

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

101

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)
(b) 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 Grantsburg Ill Date signed 2-3-43