

S. No. 2  
M-9-4-1  
5-17-39  
I X29424

Pott 1891

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 202

JUL 12 1943

Registration District No. 184

Primary Registration District No. 3038

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

58  
2

1. PLACE OF DEATH

(a) County Linn

(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 802 Brunswick Ave. 1  
(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: 58

(a) State Missouri (b) County Linn

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Brookfield - Route 2  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME GEORGE MICHAEL WALSH

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Cora Sarah Walsh 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov - 8 - 1869  
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 7 If less than one day \_\_\_\_\_ min.

9. Birthplace St Catherine Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name G. M. Walsh

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

14. Maiden name Margt M. Moxon

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

16. (a) Informant James Walsh

(b) Address Brookfield Mo

17. (a) Burial (b) Date thereof June - 18 - 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Michael

18. (a) Signature of funeral director St Michael Funeral Chapel

(b) Address Brookfield Mo

19. (a) 6-18-43 (b) W. W. Cannon  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15 year 1943 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov - 6 1942 to June 15 1943

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral aneurysm 1 mo

Due to Cerebral aneurysm 8 mo

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 518

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? \_\_\_\_\_

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

23. Signature W. A. Potts (M. D. or other) MD

Address Brookfield Mo Date signed 6-17-43

436 (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.....

*J. H. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address *Brookfield 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.**