

No. 2
4-41
7-39
X28390
11 11

Registration District No. 12

Primary Registration District No. 1053

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Viola, Missouri - Shell house
(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 Missouri (b) County Barry

(c) City or town Berryville, Ark. Rt. 1
(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 Calvin William Wall

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nettie Allen

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased March 19 1875
(Month) (Day) (Year)

8. AGE:

| | | | |
|-------|--------|------|----------------------|
| Years | Months | Days | If less than one day |
| 68 | 4 | 0 | hr. _____ min. |

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER {

12. Name Lewis Wall

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

14. Maiden name Cynthia McCrill

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

16. (a) Informant Nettie Allen Wall

(b) Address Berryville Rt. 1

17. (a) Burial (b) Date thereof July 21, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McGuire

18. (a) Signature of funeral director Nelson Funeral Home

(b) Address Berryville, Arkansas

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Post 5200
7-19-43 to 7-19-43
that I last saw him alive on 6-14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Maligancy of hip & metastasis to post 12/2/43

Due to _____

Due to _____

Other conditions probably pneumonia
(Include pregnancy within 3 months of death)

Major findings: 13 fl

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 A. J. [unclear] (M. D. or other) _____

Address Berryville, Ark. Date signed 7-21-43

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

Carter

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 12 Primary Registration District No. 5053 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Shell Knob, Mo
(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) (Specify whether

3. (a) PRINT FULL NAME Calvin Wm Wall

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

4. Sex M 5. Color of race N 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 17
(Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days _____ (less than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

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) 9/25/43 (b) Zeel Sullivan
(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 July 1943
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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?
While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

27595