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No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 108

EU NOV 8 1943 141
Registration District No. _____

Primary Registration District No. 5551

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

1. PLACE OF DEATH:

(a) County Howell

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

(c) Name of hospital or institution: Hennrich Run
(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 70 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County Howell

(c) City or town West Plains 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 Safayite J. Wall

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25 year 1943 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from July 20th, 19 43 to Sept. 10th, 19 43
that I last saw him alive on Aug. 2nd, 19 43
and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race W

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

6. (b) Name of husband or wife Martha Wall

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

7. Birth date of deceased Jan 10 - 1856
(Month) (Day) (Year)

Immediate cause of death Myocarditis Chronic with mitral regurgitation.

Duration ?

8. AGE: Years 87 Months 8 Days 15 If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) gnd

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

10. Usual occupation Retired Farmer

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name Mo Wall

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

14. Maiden name Ruth Dason

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

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? _____

16. (a) Informant Gas Houter

(b) Address West Plains Mo Rt 1

17. (a) 10 (b) Date thereof 9-27-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Hill

18. (a) Signature of funeral director Pherson

(b) Address West Plains Mo

19. (a) 10/31-43 (b) Paul Harlow
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of Injury _____

23. Signature A. H. Thornburgh (M. D. or other) _____
Address West Plains, Mo. Date signed 10/31/43

112)

RECEIVED

District Health Officer No. 5,

District File Number 1143631

Date Filed 11-5-43

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 A. S. Roberts.....

Licensed Embalmer No. 3433

P. O. Address West Haven, Ct.

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.