

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35108

FILED NOV 12 1943

State File No. _____

Registration District No. 383

Primary Registration District No. 5655

Registrar's No. 168

1. PLACE OF DEATH:

(a) County Lauerence
(b) City or town Mt Vernon Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Mo State San
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 37 days
(Specify whether
In this community 57 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dasonade
(c) City or town Quenerville 037
(If outside city or town limits, write "RURAL")
(d) Street No. R. 2
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Hilda Wolking

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

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Paul Wolking 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Aug 3 1896
(Month) (Day) (Year)

8. AGE: Years 47 Months 2 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Williams

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

14. Maiden name Mary H. Eld

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

16. (a) Informant McGeehan, Record Clerk

(b) Address Mo State San, Mt Vernon

17. (a) Removal (Burial, cremation, or removal) Quenerville Mo (b) Date thereof 10 25 43
(Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director Geo B Orr
(b) Address 224 Vernon Mo

19. (a) 10/26/43 (b) Judy Campbell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25th
year 1943 hour 4:50 minute _____ A. M.

21. I hereby certify that I attended the deceased from Aug 30 1943 to Oct 25 1943
that I last saw her alive on Oct 24 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tbc Duration over 16 mo.

Due to _____

Due to _____

Other conditions the laryngitis, Rheumatic N. Dis?
(Include pregnancy within 3 months of death)

Major findings: Of operations 13 fl

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 O Charles Brasher (M. D. or other) M.D.
Address Mt. Vernon, Mo. Date signed 10 25 43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 1143-1200

Date Filed NOV 3 1943

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

Geo. B. Orr

Licensed Embalmer No. 946

P. O. Address Ma. Vernon 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 283

Primary Registration District No. 5655

Registrar's No. 168

1. PLACE OF DEATH:

- (a) County Lawrence
- (b) City or town West Union, Iowa
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
Ms. State San.
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Hilda Walking

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 m

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

7. Birth date of deceased aug 2 (Month) (Day) (Year)

8. AGE: Years 47 Months 2 Days _____ (Specify less than one day) min. _____

9. Birthplace _____ (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) _____ (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)

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 1943 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

NOV

15704

35108