

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

Registration District No. 341

Primary Registration District No. 61632

1. PLACE OF DEATH:
 (a) County Stoddard
 (b) City or town Rural Liberty Twp.
 (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)

8. (a) PRINT FULL NAME Joyce Ileen Walls
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color of race White 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 July 26 1943
 (Month) (Day) (Year)

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

9. Birthplace Stoddard Co. Mo. 0
 (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Sam Walls
 13. Birthplace Stoddard Co. Mo. 0
 (City, town, or county) (State or foreign country)
 14. Maiden name Bernice Goodrich
 15. Birthplace New Madrid Co. Mo. 0
 (City, town, or county) (State or foreign country)

16. (a) Informant Sam Goodrich
 (b) Address Dexter, Mo.

17. (a) Burial (b) Date thereof 7-28-43
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Dexter Cemetery

18. (a) Signature of funeral director Blankenship-Strickland
 (b) Address Dexter, Mo.

19. (a) 12-4-43 (b) Nora Smith
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 103
 (a) State Missouri (b) County Stoddard 0
 (c) City or town Rural 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. Dexter R #4
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26
 year 1943 hour 7 minute 30 P. M.

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

Immediate cause of death Acute Enteric Colitis Duration 5 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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Dexter Mo (M. D. or other) 20
 Date signed 10/30/43

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

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RECEIVED

District Health Office No. 2

District File Number 164-46

Date Filed 1-5-44

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, above space should be left blank.