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5-42
5-17-39
X32873

FILED FEB 16 1944

Registration District No.

Primary Registration District No. 5177

Registrar's No.

1. PLACE OF DEATH:

(a) County Miller
(b) City or town Rural - Equality
(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 7 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Taney
(c) City or town Kirbyville, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME WALTER HUMPHREY

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 single

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

7. Birth date of deceased Oct-9-1877
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

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 Social Security Office

(b) Address Piney Bluff Mo

17. (a) Burial (b) Date thereof 1-6-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Piney Bluff, Mo

18. (a) Signature of funeral director O. L. Casey

(b) Address Boonville Mo

19. (a) 1-12-43 (b) O. C. Wright
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5
year _____ hour 8 minute 2 M.

21. I hereby certify that I attended the deceased from Jan 3 to Jan 5, 1944
that I last saw him/her alive on Jan 3, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis with influenza
Due to _____
Due to _____

Other conditions 93d
(Include pregnancy, within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 2

23. Signature W. E. Humphrey (M. D. or other) D.O.
Address Piney Bluff, Mo Date signed 1-10-43

Duration 10 yrs
4 days
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

RECEIVED

Miller County Health Dept.

County File Number 44-28

Date Filed 1-11-88

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.

No Embalming

Signed *C. L. Casey*

Licensed Embalmer No. 9694

P. O. Address *Jerua, 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.

MAR

State File No.

Registration District No. 241

Primary Registration District No. 5277

Registrar's No.

1. PLACE OF DEATH:

(a) County Miller
(b) City or town Rural Equality 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

3. (a) PRINT FULL NAME Walter Humphrey

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

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

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

7. Birth date of deceased Oct 9 1944
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace not available (City, town, or county) (State or foreign country)

14. Maiden name not available

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) A.C. Wright (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 Jan day 10 year 1944 hour _____ minute _____ M.

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

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

7778