No. 2-
2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1944

Registration District No. 251

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3048

7907

State File No.

Registrar's No. 29

1. PLACE OF DEATH:
(a) County: Nodaway
(b) City or town: Maryville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days
In this community: 16 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Nodaway
(c) City or town: Maryville
(If outside city or town limits, write "RURAL")
(d) Street No.: 518 East 1st
(If rural, give location)
(e) Citizen of foreign country? (Yes or No): No
If yes, name country

3. (a) PRINT FULL NAME: Mary Caroline Walk
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: female
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Andrew J. Walk
6. (c) Age of husband or wife if alive: 79 years
7. Birth date of deceased: February (Month) 27 (Day) 1871 (Year)
8. AGE: Years 72 Months 11 Days 14 If less than one day hr. min.
9. Birthplace: Lacona Iowa (City, town, or county) (State or foreign country)
10. Usual occupation: housewife
11. Industry or business:
MOTHER FATHER
12. Name: Christian Sherman
13. Birthplace: UNKNOWN (City, town, or county) Germany (State or foreign country)
14. Maiden name: Caroline Rennfiger
15. Birthplace: UNKNOWN (City, town, or county) Germany (State or foreign country)
16. (a) Informant: Andrew J. Walk
(b) Address: Maryville Missouri
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 2-14-44 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Marys cemetery
18. (a) Signature of funeral director: Price Funeral Home
(b) Address: Maryville Mo
19. (a) Feb. 15-44 (Date received local registrar) (b) Amy Barber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 11 year 1944 hour 3 minute 20 a. M.
21. I hereby certify that I attended the deceased from June 1940, 19..., to 2-11, 1944, that I last saw her alive on 2-10, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture of left femur / Fell down. — Duration: 2-8-44
Due to: Arteriosclerosis Hypertension, Myocarditis
Due to: Terminal Bronchial Pneumonia
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? (Specify type of place)
While at work?
(e) Means of injury: ✓
23. Signature: J. M. Boyler (M. D.) MD
Address: Maryville Date signed 2-12-44

1349 (Licensed Embalmer's Statement on Reverse Side)

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 Glen M. Price

Licensed Embalmer No. 1822

P. O. Address Maryville 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.

No. 2B
7—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 29

1. PLACE OF DEATH:

(a) County Nodaway

(b) City or town Maryville
(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 (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

3. (a) PRINT FULL NAME Mary C. Walh

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 Feb. 27 1871
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 16 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 41
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of left femur fell down — Duration 2-8-44

Due to arteriosclerosis Hypertension Myocarditis

Due to Terminal Bronchial Pneumonia

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 1860
Of autopsy 39

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) fell down on side walk fracture of femur

(b) Date of occurrence 2-8-44

(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Date signed

SUPPLEMENTARY

7907