

Registration District No. **373**

Primary Registration District No. **4245**

Registrar's No. **12**

1. PLACE OF DEATH:

(a) County **Webster**
(b) City or town **Marshfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **x**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **x**
In this community **34 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Webster**
(c) City or town **Marshfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **x** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **x**

3. (a) PRINT FULL NAME **Willie Matilda Wallraff**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife: **x** 6. (c) Age of husband or wife if alive: **x** years

7. Birth date of deceased: **June - 15 - 1871**
(Month) (Day) (Year)

8. AGE: Years **72** Months **7** Days **29** If less than one day **x** hr. **x** min.

9. Birthplace **Scotland County, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Lawrence Wallraff**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Davis**

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

16. (a) Informant **Jess Wallraff**

(b) Address **Marshfield, Missouri**

17. (a) **Burial** (b) Date thereof: **2-16-44**
(Burial, cremation, or entombment) (Month) (Day) (Year)

(c) Place: burial or cremation **Marshfield**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Marshfield, Missouri**

19. (a) **Mar. 7 1944** (b) **Charlotte Bruce**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **14**
year **1944** hour **8:10** minute **p.m.**

21. I hereby certify that I attended the deceased from **Feb. 11**, 19**44**, to **Feb. 14**, 19**44**.
that I last saw her alive on **Feb. 12**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **3 days**

Due to **Vascular Hypertensive Disease** Unknown

Due to

Other conditions (Include pregnancy within 3 months of death) **[Signature]**

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) **no**
(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 **C.P. Macdonnell, M.D.** (M. D. or other) **M. D.**
Address **Marshfield, Mo.** Date signed **2/14/44**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 344-319

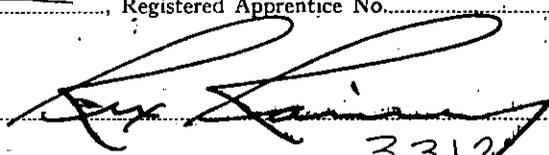
Date Filed MAR 14 1944

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. 3312

P. O. Address Marshfield, 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.