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ev. 5-17-39
I X36671

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. 18660

FILED JUN 3 1944

Registration District No. 2

Primary Registration District No. 3043

Registrar's No. 167

64
3
4

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Leversing Hosp. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution about 3 wks. (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64

(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL") 4

(d) Street No. 118a N. Third
(If rural, give location)

(e) Citizen of foreign country? ~~yes~~ No (Yes or No)

If yes, name country O

3. (a) PRINT FULL NAME Abram Ambrose Palmer Walden

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race Wht.

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Hallie Iona Walden

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Jan. (Month) 12 (Day) 1861 (Year)

8. AGE: Years 82 Months 4 Days 18 If less than one day hr. min.

9. Birthplace Meringo County (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Sewing machine Repairman

11. Industry or business

FATHER
12. Name Abram Palmer Walden
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Chas. J. Walden

(b) Address Camp Robinson, Ark

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May (Month) 3 (Day) 1944 (Year)

(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director Roy P. Schwartz

(b) Address 1000 Broadway

19. (a) 5-13-44 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 30 year 1944 hour 8 minute 10 A.M.

21. I hereby certify that I attended the deceased from April 1 1944, 19__, to April 30, 1944, that I last saw him alive on April 30, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Chr myocarditis

Due to 930

Due to

Other conditions Hypertrophied Prostate
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 [illegible] (M. D. ~~or other~~)

Address [illegible] Date signed 5/12/44

(Licensed E[illegible])

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 Roy P. Schwartz

Licensed Embalmer No. 1765

P. O. Address 1600 Broadway

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.