

17-39  
X37823  
FILED JAN 13 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. **5486**

Registrar's No. **124**

1. PLACE OF DEATH:

(a) County **Harrison**  
(b) City or town **Martinsville Dalliss Twp**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Martinsville Home**  
(If not in hospital or institution, write street number or location) **B**  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **70 Years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Harrison** **41**  
(c) City or town **Martinsville City**  
(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 **Julia Francis Walter**

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

4. Sex **F** 5. Color **W** 6. (a) Single, widowed, married, divorced **W**  
7. Birth date of deceased **Apr 11 1846**  
(Month) (Day) (Year)

8. AGE: Years **98** Months **7** Days **21** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Joseph Zumwalt**  
13. Birthplace **Clay County Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabath McDaniel**  
15. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank Glenn**  
(b) Address **Martinsville Mo**

17. (a) **Burial** (b) Date thereof **Dec 3 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Kidwell Cemetry**

18. (a) Signature of funeral director **W. G. Noble**  
(b) Address **New Hampton Mo**

19. (a) **12-30-1944** (b) **Zula M. Burres**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **2nd**  
year **1944** hour **1** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Aug 5<sup>th</sup>** 1944, to **Dec 2<sup>nd</sup>** 1944  
that I last saw him alive on **Oct 2<sup>nd</sup>** 1944 and that death occurred on the date and hour stated above.

Immediate cause of death **Hemiplegia**

Due to \_\_\_\_\_

Due to **g3d**

Other conditions (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 \_\_\_\_\_

23. Signature **W. G. Noble** (M. D. or other) \_\_\_\_\_

Address **New Hampton Mo** Date signed **Dec 3, 1944**

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

**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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

W. G. Noble

Licensed Embalmer No. 2904

P. O. Address

New Hampton

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 124

Registration District No. 233

Primary Registration District No. 5486

1. PLACE OF DEATH:

(a) County Harrison  
(b) City or town Marysville - Dallas  
(If outside city or town limits, write "RURAL" and name of town)  
(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

Julia F. Walter

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 W

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased April

(Month)

(Day)

(Year)

8. AGE:

Years 98

Months 4

Days \_\_\_\_\_

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation Wife

Housewife

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 \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Feb 15 1945 (b) Zola M. Burris

(Date received local registrar)

(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 all  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration \_\_\_\_\_

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) \_\_\_\_\_  
Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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