

S. No. 2
M-5-43
5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

nr zion (28228)

State File No. _____

FILED FEB 12 1945

Registrar's No. 17

Registration District No. 200

Primary Registration District No. 3041

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

1. PLACE OF DEATH:
(a) County macon
(b) City or town macon
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County macon
(c) City or town macon
(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 George A Walters
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 26
year 1945 hour 10:15 minute a M.

4. Sex MO 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 Dec 1-1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1 1945 to Jan 26 1945
that I last saw him alive on Jan 27 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
75 1 25 hr. min.

Immediate cause of death Chronic nephritis
Due to Cardio-vascular renal disease with cerebral thrombosis
3 yrs

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

10. Usual occupation Retired farmer

11. Industry or business _____

12. Name George A Walters

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Mrs A Stevens

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs G A Walters
(b) Address macon mo

17. (a) burial (b) Date thereof 1/28/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Salem cem
18. (a) Signature of funeral director Robert S Kegan
(b) Address macon mo

19. (a) 2/2/45 (b) Jara B Stunkler
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
1316

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?

23. Signature J.P. Brownway (M. D. or other)
Address macon Mo Date signed 1-29-45

1037

RECEIVED

District Health Officer No. 10

District File Number *2-45-258*

Date Filed *FEB 11 1945*

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 *Robert Skinner*

Licensed Embalmer No. *75-1*

P. O. Address *Macoumas*

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.