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10409

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 21 1945
Registration District No. 275

Primary Registration District No. 4409

Registrar's No. 364

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Waverly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether years, months or days) 4 mos

3. (a) PRINT FULL NAME Bileen Jean Wadson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex W 5. Color or race W 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 9 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 13 _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business ?

12. Name _____

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

14. Maiden name Ruth Wadson

15. Birthplace Shelby Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Ruth Wadson
(b) Address Waverly

17. (a) Funeral (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rocky Cemetery

18. (a) Signature of funeral director Lee Johnson
(b) Address Waverly Mo

19. (a) 2/23/45 (b) St. Charles, Mo
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
(c) City or town Waverly
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22
year 1945 hour 6 minute 0 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him live on Feb 22, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Sabon Pneumonia
malnutrition

Due to _____

Due to _____

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 3

23. Signature S. Salauide (M.D. or other) Waverly

Address Waverly, Mo Date signed 2/23/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1092

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by

working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No.

P. O. Address

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.