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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED MAY 25 1945

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16514

State File No. \_\_\_\_\_

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 1166

1. PLACE OF DEATH:

(a) County CALLAWAY

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

(c) Name of hospital or institution FULTON  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community LIFE  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALLAWAY

(c) City or town FULTON  
(If outside city or town limits, write "RURAL")

(d) Street No. 810 Bkuff  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WALLACE Wheeler ZUMWALT

3. (b) If veteran, name war ✓

3. (c) Social Security No. —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12  
year 1945 hour 11 minute 30 A. M.

4. Sex MALE

5. Color or race White

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

6. (b) Name of husband or wife Oda

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

7. Birth date of deceased: Feb (Month) 16 (Day) 1878 (Year)

21. I hereby certify that I attended the deceased from 1-5-45, 19\_\_\_\_ to 5-9, 1945  
that I last saw him alive on 5-9-9, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

67 2 26 hr. min.

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

Immediate cause of death Coronary Occlusion

Due to Coronary Sclerosis

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

Duration 30 min

1 yr.

10. Usual occupation FARMER

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

12. Name J. J. ZUMWALT

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

14. Maiden name HENCHINS

15. Birthplace CALLAWAY Co. MO  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations None

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant MRS. W. W. ZUMWALT

(b) Address FULTON, MO

17. (a) BURIAL (b) Date thereof MAY 14, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HILL-CREST FULTON

18. (a) Signature of funeral director Glenn Y. Mansour

(b) Address 412 Court St. Fulton, Mo.

19. (a) May 14, 1945 (b) Joan Mansour Hoff  
(Date received local registrar) (Registrar's signature)

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)

(b) Manner of injury \_\_\_\_\_

23. Signature John J. Brown M. D. or other \_\_\_\_\_

Address Fulton Date signed 5-14-45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-24-45

MAY 8 1945

MAY 28 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 Glen Y. Manpin

Licensed Embalmer No. 27215

P. O. Address Fulton, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June 166  
Registrar's No. \_\_\_\_\_

Registration District No. 47 Primary Registration District No. 3008

**1. PLACE OF DEATH:**

(a) County Callaway  
 (b) City or town Shulton  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution H.K.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 years, months or days

**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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** Wallace W. Zumwalt  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month May year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

4. Sex m 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 Feb 16 1885  
(Month) (Day) (Year)  
 8. **AGE:** Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_  
 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
 19. (a) \_\_\_\_\_ (b) Josie M. ...  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(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? \_\_\_\_\_  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**SUPPLEMENTARY**

16514