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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23376**

**FILED** AUG 2 1945  
Registration District No. **11**

Primary Registration District No. **4025**

Registrar's No. **42**

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

1. PLACE OF DEATH:  
(a) County **Barry**  
(b) City or town **Wheaton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Wheaton Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **One Day**  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME **Billie Joe Michael**  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**  
7. Birth date of deceased **July 9 1930**  
(Month) (Day) (Year)

8. AGE: Years **14** Months **11** Days **1** If less than one day  
hr. min.

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

10. Usual occupation **None**

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

MOTHER FATHER {  
12. Name **Walter Michael**  
13. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Doga Waldon**  
15. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Walter Michael**  
(b) Address **Rocky Comfort, Mo. R#**

17. (a) **Burial** (b) Date thereof **6/11/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Rockycomfort Cem**

18. (c) Signature of funeral director **Wm. Merna Doga**  
(b) Address **Wheaton, Mo.**

19. (a) **July 3-1945** (b) **Grace Williams**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **McDonald**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Rockycomfort, Mo. R#**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **10**  
year **1945** hour **12** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **June 10 1945**  
to **June 10 1945**  
that I last saw him alive on **June 10 1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Valvular Heart Disease**  
Duration **10 yrs.**

Due to **Acute Rheumatic Fever**  
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 **John R. Eason** (M. D. or other) **Mo.**  
Address **Wheaton Mo.** Date signed **June 20 1945**

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RECEIVED

Health Officer No. 67

File Number 745-843

Date Filed JUL 31 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 *W. M. ...*

Licensed Embalmer No. *3642*

P. O. Address *Wheaton, 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.