

FILED JUL 16 1945
70

State File No. _____

Registration District No. _____

Primary Registration District No. 5283

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Williamstown Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Union Inf
(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 Mo. (b) County Clark
(c) City or town Williamstown Rural
(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 Sydney Eleanor Walker

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife C. M. Walker 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Nov. 16-1880
(Month) (Day) (Year)

8. AGE: Years 64 Months 7 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housekeeping

11. Industry or business _____

MOTHER FATHER { 12. Name James Wadmore

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

14. Maiden name Emma Jane Kirkhead

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

16. (a) Informant C. M. Walker

(b) Address Williamstown Mo. 0

17. (a) Buried (b) Date thereof May 25-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Neerer Co.

18. (a) Signature of funeral director Settlage Wood

(b) Address Kalaska Mo

19. (a) 6-7-45 (b) Paul Boston
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1945 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from May 23, 1945, to May 23, 1945
that I last saw her alive on May 23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the ovary
Duration 7 1/2

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations H&H

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 2 DO

23. Signature Dr. C. E. Ford (M.D. or other) 2 DO

Address Williamstown Mo Date signed 6/2/45

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

AUG 9 1945
AUG 7 1945
AUG 6 1945

JUN 29 1950

RECEIVED

District Health Officer No. 10
District File Number 7-45-1110
Date Filed JUL 13 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 Chas. L. Luttinger
Licensed Embalmer No. 2965
P. O. Address Peru

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.