DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17274

FILED JUN 6 1946

Registration District No. 3083 Primary Registration District No. 3039 Registrar's No. 85

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

1. PLACE OF DEATH:
(a) County LINN
(b) City or town MARCELINE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CHESTNUT & BARBOUR 1
(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)
In this community 26 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County LINN
(c) City or town MARCELINE
(If outside city or town limits, write "RURAL")
(d) Street No. CHESTNUT & BARBOUR 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ROLLY WILLIAM WALL

3. (b) If veteran, name war WORLD WAR I

3. (c) Social Security No. 496-22-7826

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife ELSIE WALL

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased SEPTEMBER 6 (Month) (Day) (Year)

8. AGE: Years 48 Months 7 Days 26 If less than one day ..... hr. ..... min.

9. Birthplace BLAIRSTOWN (City, town, or county) MO (State or foreign country)

10. Usual occupation OIL JOBBER

11. Industry or business

FATHER
12. Name CHARLES O. WALL
13. Birthplace HENRY CO. (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name SUSAN L. DAVIS
15. Birthplace UNKNOWN (City, town, or county) KY. (State or foreign country)

16. (a) Informant MRS. ROLLY WALL
(b) Address MARCELINE, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-5-46 (Month) (Day) (Year)
(c) Place: burial or cremation MT. OLIVE CEMETERY

18. (a) Signature of funeral director Nelson Funeral Home
(b) Address Chillicothe, Mo.

19. (a) MAY 3-1946 (Date received local registrar) (b) L. Shelton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd year 1946 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 10, 1946, to May 2, 1946, that I last saw him alive on 3-18, 1946, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Liver	4 month
Due to: Carcinoma of Gall bladder	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: cholecystitis & thickening of common duct
Of autopsy:

PHYSICIAN — Underline the cause to which death would be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature F. L. McDonnick (M. D. or other) M.D.
Address Moberly Mo Date signed 6-2-46

168 (Licensed Embalmer's Statement on Reverse Side)

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 Ellen F. Norman, Registered Apprentice No. working under my personal supervision.

Signed Ellen F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.

No. 2B
—3-45
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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. June

Registration District No. 385 Primary Registration District No. 0029 Registrar's No. 85

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

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 Rolly W. Wall
3. (b) If veteran, name war
3. (c) Social Security No.
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 Sept. (Month) (Day) (Year)
8. AGE: Years 48 Months 7 Days 26 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 2 day year 1946 hour P.M. minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cancer of liver	
Due to Cancer of Gall bladder	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature A. L. McCormick (M.D. or other) M.D.
Address Date signed

SUPPLEMENTARY

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

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JUN 19 1947