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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 5 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23040

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 94

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 months, 4 days (Specify whether years, months or days)
In this community 5 months, 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Arkansas (b) County: Marion
(c) City or town: Yellville,
(If outside city or town limits, write "RURAL")
(d) Street No.: None
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Eldridge M. Wall
3. (b) If veteran, name war: World War I
3. (c) Social Security No.: 227-26-3993
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Ruby Wall
6. (c) Age of husband or wife if alive: 40 years
7. Birth date of deceased: April 1, 1894 (Month) (Day) (Year)
8. AGE: Years 52 Months 3 Days 17 If less than one day hr. min.
9. Birthplace: Wetumpka, Alabama (City, town, or county) (State or foreign country)
10. Usual occupation: U. S. Army-Retired
11. Industry or business: "
FATHER 12. Name: Thomas Wall
13. Birthplace: ? (City, town, or county) ? (State or foreign country)
MOTHER 14. Maiden name: Virginia Jackson
15. Birthplace: ? (City, town, or county) ? (State or foreign country)
16. (a) Informant: Hospital Records, Veterans Administration,
(b) Address: Excelsior Springs, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-19-46 (Month) (Day) (Year)
(c) Place of burial or cremation or removal: Lindale, Texas
18. (a) Signature of funeral director: HOPE FUNERAL HOME,
(b) Address: Excelsior Springs, Missouri
19. (a) 7/22/46 (Date received local registrar) (b) Caroline Hutchings (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1946 hour 7:41 minute A. M.
21. I hereby certify that I attended the deceased from February 14, 1946, to July 19, 1946 that I last saw him alive on July 19, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis, pulmonary, chronic, far advanced, active.	Unknown
Due to:	
Due to:	
Other conditions: Tuberculous, laryngitis. (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy: No autopsy performed.	

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: ERNEST M. TAPP, M.D. (M.D. or other)
Address: Veterans Administration Hospital Excelsior Springs, Mo. Date signed 7-19-46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-3-46

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 J. A. Moles

Licensed Embalmer No. 3296

P. O. Address Ex Springs 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.