

1. PLACE OF DEATH:
 (a) County Osage Co Rural
 (b) City or town Chamois Mo Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ (years, months or days) at the site

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Osage 76
 (c) City or town Chamois 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 Jane Walker
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 6
 year 1946 hour 3 minute A.M.
 21. I hereby certify that I attended the deceased from 8/21 1946 to 12/6 1946
 that I last saw him alive on 12/6/46 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Frank Walker 6. (c) Age of husband or wife if alive 62 years
 7. Birth date of deceased Man 27 1878
 (Month) (Day) (Year)

Immediate cause of death Myocardial degeneration
 Due to arteriosclerosis
 Due to ⊕

8. AGE:
 Years 68 Months 8 Days 9 If less than one day 3 hr. _____ min. _____

Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

9. Birthplace Deer Creek Mo Rural (City, town, or county) (State or foreign country) U
 10. Usual occupation House Wife

MOTHER FATHER
 11. Industry or business _____
 12. Name Dennis Glavin
 13. Birthplace Ireland (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Brothers
 15. Birthplace Ireland (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
AM

16. (a) Informant Frank Walker
 (b) Address Chamois Mo
 17. (a) Burial (b) Date thereof 12-9-1946
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Catholic Cemetery Chamois
 18. (a) Signature of funeral director Otto T. Stockpach
 (b) Address Chamois Mo
 19. (a) 12-6-46 (b) Ether Souden
 (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) (e) Means of injury _____
 23. Signature L. E. Giffen D.O. (M.D. or other) _____
 Address Chamois Mo Date signed 12/6/46

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

Date Filed 12-9-46

District File Number

District Health Officer No. 9

RECEIVED

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 Otto Stocksick

Licensed Embalmer No. 1902

P. O. Address Chamois, 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.

State File No. *Jan 18*
Registrar's No. *18*

Registration District No. *256* Primary Registration District No. *5879*

1. PLACE OF DEATH:

(a) County *Osage*
(b) City or town *Rural*
(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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

Jane Walker

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *Frank* 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *man 2* (Month) (Day) (Year)

8. AGE: Years *68* Months _____ Day _____ If less than one day hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) *E. Arthur Souder* (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year *1946* Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

41528