

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town OSAGE TWP
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
OAKLAND
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 33 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE 53

(c) City or town RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. OAKLAND MO
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LULA WALLIN

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 7
year 1947 hour 10 minute P. M.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife W. E. WALLIN 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased NOV 14 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 15, 1946 to Jan 7, 1947
that I last saw Per alive on Dec 31, 1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

64 1 23 hr. min.

Immediate cause of death myocardial failure Duration 1 hr.

Due to Chronic myocarditis 1 yr.

Due to mitral stenosis unk.

9. Birthplace WEST VA.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

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

11. Industry or business _____

MOTHER FATHER { 12. Name D. B. LYON

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

14. Maiden name MARY MUNSEY

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

Major findings: Of operations 92 B

Of autopsy _____

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

16. (a) Informant W. E. Wallin

(b) Address OAKLAND MO

17. (a) BURIAL (b) Date thereof 1-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON MO

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) Jan 18, 1947 (b) Geo Frankenberg
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)
Means of injury 0

23. Signature James H. Hope (M. D. or other) _____
Address Lebanon, Mo Date signed 1/10/47

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

Received 1/28/47
Laclede County Health Unit
File No. 1-47-1
Date Filed 1/28/48

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 *D. Palmer*
Licensed Embalmer No. 1161
P. O. Address *Laborer 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.