. S. No. 2
DM—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 10 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21350

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 145

1. PLACE OF DEATH:
(a) County JASPER
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BANK OF CARTHAGE BLDG 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs (Specify whether
In this community 57 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JASPER 49
(c) City or town Carthage 1
(If outside city or town limits, write "RURAL")
(d) Street No. 420 Euclid 3
(If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIS WALLINGFORD
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Nelle Hamilton Wallingford
6. (c) Age of husband or wife if alive ——— years
7. Birth date of deceased JANUARY (Month) 6 (Day) 1879 (Year)

8. AGE: Years 68 Months 5 Days 24 If less than one day ..... hr. ..... min.

9. Birthplace MILFORD (City, town, or county) Kentucky (State or foreign country) 1
10. Usual occupation Retired Merchant & Judge
11. Industry or business

FATHER
12. Name A.M. WALLINGFORD
13. Birthplace unknown (City, town, or county) Kentucky (State or foreign country) 1

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Mrs Mills Anderson JR
(b) Address 803 S. Garrison - Carthage Mo
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7-3-47 (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery
18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Mo.
19. (a) 7-1-47 (Date received local registrar) (b) L. B. Clinton M.D. (Registrar's signature) 124

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30th year 1947 hour 10 A minute ..... M.

21. I hereby certify that I attended the deceased from 6-30 ..... 1947 to 6-30 1947 that I last saw him alive on 30 June 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary occlusion	15 minutes
Due to Arteriosclerosis and Hypertension	10 years.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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) 0
While at work? (e) Means of injury

23. Signature W. T. McNew (M. D. or other) MD
Address 304 Grant Carthage Mo. Date signed 6-30-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

47-6-575

JUL 31 1947

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 Frank W. Kuell Jr

Licensed Embalmer No. 4440

P. O. Address Carthage

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.