

S. No. 2
M-5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28364

State File No. _____

Registrar's No. 298

Registration District No. 209

Primary Registration District No. 3043

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

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: ST. Elizabeth Hosp. Tal O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64

(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2303 Spruce 4
(If rural, give location)

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

3. (a) PRINT FULL NAME Tilden E. Walden

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August, day 20
year 1947, hour _____ minute 10:45 A.M.

21. I hereby certify that I attended the deceased from _____
1946, to Aug 20, 1947
that I last saw him alive on August 20, 1947
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased: Sept. 5, 1876
(Month) (Day) (Year)

Immediate cause of death Noddykins Disease

Due to _____

Due to _____

Other conditions Ch. Myocardite
(Include pregnancy within 3 months of death)

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

70 11 15 hr. min.

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

10. Usual occupation Gas Wheel Foundry

11. Industry or business _____

12. Name Samuel S. Walden

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

14. Maiden name Mary Ellen 9

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

Major findings: Of operations _____

Of autopsy above of 11

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

16. (a) Informant Mr. C. S. Tealite

(b) Address 2417 Hope Hannibal Mo

17. (a) Burial (b) Date thereof 9-23-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Providence Cem. Marion Co.

18. (a) Signature of funeral director James O. Council

(b) Address Hannibal Mo

19. (a) 8-21-47 (b) Dr. E. M. Lucke
(Date local registrar) (Registrar's signature) 109

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 0

23. Signature [Signature] (M. D. or other) _____

Address 1061 [Address] Date signed 9/4/47

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. 497.
working under my personal supervision.

Signed..... H. M. O'Connell.....

Licensed Embalmer No. 3889.....

P. O. Address..... Hamil W......

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.