

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37858

State File No.

Registration District No. 131

Primary Registration District No. 4202

Registrar's No.

1. PLACE OF DEATH:

(a) County Grundy
(b) City or town Spickard
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Grundy 40
(c) City or town Spickard
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME

Ella Dewalt

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married 2 divorced Widowed

6. (b) Name of husband or wife Peter F. Dewalt 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov-15-1859
(Month) (Day) (Year)

8. AGE: Years 87 Months 11 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farm

11. Industry or business _____

12. Name William Blades

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

14. Maiden name unknown

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

16. (a) Informant Clarence Dewalt

(b) Address Spickard Mo.

17. (a) Burial (b) Date thereof Nov-11-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spickard Cem. Cameron Mo.

18. (a) Signature of funeral director Schoolers Funeral Home

(b) Address Spickard Mo.

19. (a) 11/19/47 (b) Addie Cooper
(Date received local registrar) (Registrar's signature) 114

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9
year 1947 hour 10 AM minute _____ M.

21. I hereby certify that I attended the deceased from Nov 9, 1947, to Nov 9, 1947
that I last saw her alive on Sept 2nd see husband
and that death occurred on the date and hour stated above.

Immediate cause of death General atrophy of
superficiality of old age
Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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 EW Ewing (M. D. or other) _____

Address Spickard Mo Date signed 11-10-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Ross Wise

Licensed Embalmer No.,

Spicker 3771

P. O. Address

Spickard 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.