No. 2
1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 3 1947

Registration District No. 3B3

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3074

State File No. 40620

Registrar's No. 92

1. PLACE OF DEATH:
(a) County: Scott
(b) City or town: Sikeston, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home 415 Harris Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: 6 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Scott
(c) City or town: Sikesto, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 413 Harriss
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: LILLIE MAHALA WALTERMATE
3. (b) If veteran name war: no
3. (c) Social Security No.: unkonwn
4. Sex: female
5. Color or race: white
6. (a) Single, widowed, married, divorced: widowed
6. (b) Name of husband or wife: Louis Waltermate
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: July 5, 1870 (Month) (Day) (Year)
8. AGE: 77 Years, Months 4, Days 16, If less than one day hr. min.
9. Birthplace: Camden, Tenn (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John Heggie
13. Birthplace: Tenn. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Mary Rushing
15. Birthplace: Tenn (City, town, or county) (State or foreign country)
16. (a) Informant: Lillian Tomlinson
(b) Address: Sikeston, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 24, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: IOOF CEMETERY, CHARLESTON, MO.
18. (a) Signature of funeral director: Orville Taylor
(b) Address: Sikeston Mo
19. (a) 11-29-47 (Date received local registrar) (b) Mrs P F Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20-Nov-47 day year hour 1:00 P.M. minute M.
21. I hereby certify that I attended the deceased from 16-Oct-47, 19, to 20-Nov-47, 19; that I last saw her alive on 19-Nov-47, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia	2-3 days
Due to: Cerebral Hemorrhage	1 mo.
Due to: Hypertension	Several years
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: NONE	
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)
While at work? (e) Means of injury
23. Signature: H. B. Throgmorton (M. D. or other)
Address: Sikeston, Mo. Date signed: 29-Nov-47

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1247-1517
Date Filed 12-1-47

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. ..... working under my personal supervision.

Signed James M Scott

Licensed Embalmer No. 4350

P. O. Address East Prairie, Me

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40620

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 92

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(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)

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

3. (a) PRINT FULL NAME Lillie M Waltermate

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 Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased July (Month) 5 (Day) 1870 (Year)

8. AGE: Years 77 Months 4 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 20 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia — Duration 4 days

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 107

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature H B Throgmorton (M. D. or other)

Address Sikeston, Mo. Date signed 17-Mar-47