

No. 2
1-147
5-17-39

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED MAY 25 1948
Registration District No. 227

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 4339

State File No. 17015
Registrar's No. 27

1. PLACE OF DEATH:
(a) County MONROE
(b) City or town PARIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution FAIR VIEW HEIGHTS ST.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 70 YRS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County MONROE 69
(c) City or town PARIS
(If outside city or town limits, write "RURAL")
(d) Street No. FAIR VIEW HEIGHTS ST. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME PETER C. WILMORE
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MAY day 17
year 1948 hour 12 minute 45 A.M.
21. I hereby certify that I attended the deceased from 1947 to 1948
that I last saw him alive on 7/17/47 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 SINGLE
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive 77 years

Immediate cause of death Calvarian thrombosis
Due to arterio-sclerosis with
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations none
Of autopsy _____

8. AGE: Years 77 Months 2 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace JESSEMAN CO. KY.
(City, town, or county) (State or foreign country)
10. Usual occupation LABORER

11. Industry or business _____
12. Name JAMES WILMORE
13. Birthplace KY.
14. Maiden name MARGARET CRUTCHER
15. Birthplace KY.

16. (a) Informant CHARLES SUMMERS
(b) Address PARIS, MO.
17. (a) BURIAL (b) Date thereof MAY 12, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation WALNUT GROVE
18. (a) Signature of funeral director [Signature]
(b) Address PARIS MO.
19. (a) 5-17-48 (b) OLIVE LITTLE
(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? _____ (Specify type of place)
While at work _____ (Specify means of injury)
23. Signature [Signature] (M. D. or D. O. M.)
Address PARIS, MO. Date signed 5-17-48

PHYSICIAN
Underline the cause of which death should be charged statistically.

MOTHER FATHER

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

RECEIVED
District Health Officer N
District File Number 5-4
Date Filed MAY 24

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 E. M. Agnew

Licensed Embalmer No. 4000
P. O. Address PARIS, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 227Primary Registration District No. 4339Registrar's No. 27

1. PLACE OF DEATH:

- (a) County Monroe
 (b) City or town Paris
 (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)

3. (a) PRINT FULL NAME

Peter C. Walmon

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex

M5. Color or race W

6. (a) Single, widowed, married, divorced
- 5

6. (b) Name of husband or wife _____

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

7. Birth date of deceased
- Feb 26

(Month)

(Day)

(Year)

8. AGE:

Years 77Months 2

Days _____

If less than one day

hr. _____ min.

9. Birthplace
- Ky

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a)
- May 28/1948
- (b)
- Oliver Little

(Date received local registrar)

(Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- mar
-
- year
- 1948
- hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:

Of operations _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

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

Address _____ Date signed _____

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

MOTHER FATHER

S-17015