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FILED FEB 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1881

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal	
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence 216 Virginia		d. STREET ADDRESS (If rural, give location) 216 Virginia	

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Armeddia Walters			4. DATE OF DEATH (Month) (Day) (Year) January 21, 1949		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 6, 1867	9. AGE (In years last birthday) IF UNDER 1 YEAR 81 Months Days Hours Mts.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nicholsville Kentucky /	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME Nathan Hunter	13b. MOTHER'S MAIDEN NAME No record	14. NAME OF HUSBAND OR WIFE Wm.C.Walters
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. David A. Dunn 216 Virginia Hannibal	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr myocarditis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr nephritis		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? C

22. I hereby certify that I attended the deceased from **Jan 15** to **Jan 21**, 19**49**, that I last saw the deceased alive on **Jan 21**, 19**49**, and that death occurred at **3:15** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	23b. ADDRESS 1001 Blue Mount Cir	23c. DATE SIGNED 1-28-49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1/21/1949	24c. NAME OF CEMETERY OR CREMATORY Mount Olivet
24d. LOCATION (City, town, or county) (State) Hannibal Missouri		

DATE REC'D BY LOCAL REG. 1-28-49	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Hannibal Misso
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Student Embalmer No.

working under my personal supervision.

Signed.....

John S. Ward

Signed.....

Student Embalmer

Licensed Embalmer No. 4540

P. O. Address Hannibal Missouri

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.