

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33236
347

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cape Girardeau</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Portageville</u>	
c. LENGTH OF STAY (In this place) <u>2 wks</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D. 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Francis Hosp</u>			

3. NAME OF DECEASED (Type or Print) <u>LANDEL WALLS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 13-1949</u>		
a. (First)		b. (Middle)	c. (Last)		

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Inf</u>	8. DATE OF BIRTH <u>Aug 12-1949</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 1 HR.
				Months	Days	Hours
				2	1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inf</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
--	---	---	--

13a. FATHER'S NAME <u>John Walls</u>	13b. MOTHER'S MAIDEN NAME <u>Esther White</u>	14. NAME OF HUSBAND OR WIFE _____
--------------------------------------	---	-----------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>John Walls, Portageville, Mo</u>	ADDRESS <u>R.F.D. 1</u>
--	-------------------------------	---	-------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>INFECTIOUS DIARRHEA</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		5710	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from 27 Sept, 1949, to 13 Oct, 1949, that I last saw the deceased alive on 12 Oct, 1949, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James A. Kinley MD</u>	23b. ADDRESS <u>Cape Girardeau Mo</u>	23c. DATE SIGNED <u>13 Oct '49</u>
--	---------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-14-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Portageville</u>	24d. LOCATION (City, town, or county) (State) <u>Portageville Mo</u>
---	---------------------------	--	--

DATE REC'D BY LOCAL REG. <u>10-13-1949</u>	REGISTRAR'S SIGNATURE <u>Lo. Co. Summers</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Taken care of by family & friends</u>	ADDRESS _____
--	--	---	---------------

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

RECEIVED 10-17-49

District Health Officer No. 4

District File Number 1049-1361

Date Filed

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

Signed Student Embalmer

Licensed Embalmer No.

P. O. Address

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.