

No. 300
10. 48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37934

State File No.

FILED NOV 23 1949

BIRTH NO. _____		REG. DIST. NO. <u>200</u>		PRIMARY REG. DIST. NO. <u>5728</u>		Registrar's No. <u>122</u>	
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Round Grove</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Unabel Mo.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none</u>				d. STREET ADDRESS (If rural, give location) <u>Northeast of Macon</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>James</u> (Middle) <u>T A</u> (Last) <u>Walrath</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 23 1949</u>				
5. SEX <u>M</u> COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept 5 1883</u>		9. AGE (In years last birthday) <u>66</u> IF UNDER 1 YEAR Months <u>1</u> Day <u>18</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (State or foreign country) <u>Ok.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ok.</u>		13b. MOTHER'S MAIDEN NAME <u>O.K.</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Otchick</u>		ADDRESS <u>Macon</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fracture Neck (accident)</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Separation forward + possible fracture skull</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>abrasions legs</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1/8 x 166</u> <u>2 1/2</u>	
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) <u>accident highway 2 1/2 miles</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>VA</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>VA - 1010. With 0 Mo. 11/2</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Oct 23 1949 6P.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Car smash-up</u>			
22. I hereby certify that I attended the deceased from <u>Oct 23 1949</u> to <u>Oct 23 1949</u> , 19 <u>49</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J.B. Stokes, M.D. (Coroner)</u>				23b. ADDRESS <u>Excelsior, Mo</u>		23c. DATE SIGNED <u>10-24-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-26-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		24d. LOCATION (City, town, or county) (State) <u>Macon, MO</u>	
DATE REC'D BY LOCAL REG. <u>11-7-49</u>		REGISTRAR'S SIGNATURE <u>Iruth Mcneely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stephen's Goodding</u>		ADDRESS <u>Macon</u>	

(Licensed Embalmers' Statement on Reverse Side)

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

RECEIVED 11/14/49
MACON COUNTY HEALTH DEPARTMENT
County File No. 11/48/37
Date Filed 11/15/49

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.....

George W. Davalt

Student Embalmer No. 347

working under my personal supervision.

C. L. Stephens

Signed.....

3057

Signed George W. Davalt

Student Embalmer

Licensed Embalmer No.

P. O. Address Malcom

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.