

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

FILED NOV 3 1950

State File No. **33163**

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>115</u>                   |  | PRIMARY REG. DIST. NO. <u>5433</u>  |  | Registrar's No. _____                              |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Franklin</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>   |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Union</u>  |  | c. LENGTH OF STAY (If in place) <u>Life</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Union</u>   |  | 0360   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Beaufort Mo R#R.</u>   |  |   |  | d. STREET ADDRESS (If rural, give location) <u>Beaufort Mo R#R.</u>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Lawrence</u>   |  |   |  | b. (Middle) <u>Walde</u>  |  | c. (Last) <u>Walde</u>                             |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u>                   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>   |  | 8. DATE OF BIRTH <u>Jan 9 1888</u>                 |  |
| 9. AGE (In years last birthday) <u>62</u>  |  | 10. MONTHS <u>9</u>                         |  | 11. DAYS <u>21</u>  |  | 12. IF UNDER 1 YEAR Hours <u>24</u> Min. <u>00</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 _____   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Beaufort Mo</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |
| 13a. FATHER'S NAME <u>John Walde</u>   |  |   |  | 13b. MOTHER'S MAIDEN NAME <u>Mary Burke</u>   |  |  |  |
| 14. NAME OF HUSBAND OR WIFE _____  |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____   |  |  |  |
| 16. SOCIAL SECURITY NO. _____  |  |   |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Josephine Sieges</u> ADDRESS <u>Beaufort Mo</u>  |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>* This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  |   |  | 19. MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u><br>ANTECEDENT CONDITIONS<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>4222</u> |  |  |  |
| 19a. DATE OF OPERATION _____   |  |   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |  |  |  |
| 20. AUTOPSY?<br>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 <u>July 1948</u> , to <u>Oct 24, 1950</u> that I last saw the deceased alive on <u>10-20</u> , 19 <u>50</u> , and that death occurred at <u>8 PM.</u> , from the causes and on the date stated above.  |  |  |  |
| 23a. SIGNATURE <u>J. L. Matthews M.D.</u> (Degree or title)  |  |   |  | 23b. ADDRESS <u>Beaufort Mo</u>   |  |  |  |
| 23c. DATE SIGNED <u>10-27-50</u>   |  |   |  | 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |  |
| 24b. DATE <u>Oct 28 1950</u>   |  |   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>St Joseph Cath.</u>   |  |  |  |
| 24d. LOCATION (City, town, or county) <u>Beaufort Mo</u>   |  |   |  | 24e. (State) _____  |  |  |  |
| DATE REC'D BY LOCAL REG. <u>Oct 28-1950</u>  |  |   |  | REGISTRAR'S SIGNATURE <u>J. T. Cofer</u>  |  |  |  |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. H. Lemme</u>  |  |   |  | ADDRESS <u>Beaufort</u>   |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

OCT 30 1950

RECEIVED

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 \_\_\_\_\_

*E H Lemme*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*E H Lemme*

Licensed Embalmer No. *3076*

P. O. Address *Beaufort N*

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.