

FILED NOV 21 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33

33

BIRTH NO. _____		REG. DIST. NO. 113		PRIMARY REG. DIST. NO. 5431		Registrar's No. 33	
1. PLACE OF DEATH a. COUNTY FRANKLIN				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY FRANKLIN			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-PRAIRIE				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-PRAIRIE 0360			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print)		a. (First) OSCAR		b. (Middle) WM.		c. (Last) WALLS	
4. DATE OF DEATH		11-1-51		5. DATE OF BIRTH		FEB. 17, 1903	
6. SEX MALE		7. COLOR OR RACE WHITE		8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		9. AGE (In years last birthday) 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MO		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME SEMON WALLS		13b. MOTHER'S MAIDEN NAME ADELINE		14. NAME OF HUSBAND OR WIFE ESTHER WALLS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ESTHER WALLS LONEDELL MO			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY THROMBOSIS 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.				INTERVAL BETWEEN ONSET AND DEATH	
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) NATURAL		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) IN HOME		21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) (STATE) PRAIRIE FRANKLIN MO			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, 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		23b. ADDRESS		23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 11-9-51		24c. NAME OF CEMETERY OR CREMATORY PROSPECT		24d. LOCATION (City, town, or county) (State) LONEDELL MO	
DATE REC'D BY LOCAL REG. 11-8-51		REGISTRAR'S SIGNATURE E. L. Worthington		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Chas. J. Leroy St. Louis, MO			

(Licensed Emballer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE PERMANENT RECORD

RECEIVED
NOV 15 1951
DISTRICT HEALTH OFFICE No. 4
File No.

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 _____

Colin Forbes

Student Embalmer No. *439*

working under my personal supervision.

Student *Colin Forbes*
Student Embalmer

Signed *H. M. Leno*

Licensed Embalmer No. *3681*

P. O. Address *St. Clair, 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.