MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
21813

1. PLACE OF DEATH
County Jasper — Registration District No. 410
Township Preston — Primary Registration District No. 4243
City Jasper (No. ..... St. ..... Ward)

File No. /
Registered No. 13

2. FULL NAME Junius Winfield Wale

(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1847

7. AGE — YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
82	----	-----	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Judge of poultry & stock
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER Henry H Wale

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Mary Woolfolk

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs Fanny Mc.Indoo
(Address) Kansas City Mo.

15. FILED 7-2, 1929 W A Holmes REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 1929

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to 6/30, 1929
that I last saw h~~im~~ alive on June 30, 1929, and that death occurred, on the date stated above, at 1 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia - /
107A /
135B (duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (SECONDARY) Chronic - Cystitis
(duration) ..... yrs. ..... mos. ..... da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W H Hendrycks, M. D
, 19 (Address) Jasper Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Paradise Cem. — DATE OF BURIAL July 3 1929

20. UNDERTAKER Teeter Bros. — ADDRESS Jasper Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

26 1929 49 19 6 6 2

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jasper Registration District No. 410 File No.
Township Primary Registration District No. 4243 Registered No. 13
City (No. St. Ward)

2. FULL NAME Virginia Winfield Wale

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	Wid

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 7-2, 19 29 W. T. Holmes REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19.....
that I last saw h.... alive on ....., 19....., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Bronchopneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic cystitis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) V. N. Endicott, M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

9.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

[illegible]