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.

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

Do not use this space.

18490

JUL 20 1930

108

1

1

2

1. PLACE OF DEATH

County: Vernon. Registration District No. 875

Township: Washington. Primary Registration District No. 6162

City ..... (No. ....., ... St. ..... Ward)

File No. .....

Registered No. 129

2. FULL NAME R. W. R. Wall

(a) Residence. No. State Hosp. No 3 St. Nevada Ward. Mo.
(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)
Male	white	Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	71	10	11	

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

9. BIRTHPLACE (CITY OR TOWN) Denton,
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER R. J. R. Wall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY) No. Carolina.
12. MAIDEN NAME OF MOTHER Mary Jane ?
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTRY) No Carolina

14. INFORMANT Ira Wall (son)
(Address) Denton, Mo.

15. FILED 6/14/30 E. R. King. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31st 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1929, to May 31st, 1930 that I last saw h. alive on May 31st, 1930, and that death occurred, on the date stated above, at 11 30 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108

10/0 1 6 2

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Senile Dementia

(duration) 3 + yrs. ..... mos. ..... ds.

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

D

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) staff State Hosp. No 3 F. M. Brogan M.D.

May 31, 1930 (Address) Nevada, 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	DATE OF BURIAL
Chilhowee Mo	6/1 1930
20. UNDERTAKER	**ADDRESS**
A H Hays	Nevada Mo.