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

Do not use this space.

34598 D

File No. 337

Registered No.

1. PLACE OF DEATH

114 County Wright

Township North Grove

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

Registration District No. 908

Primary Registration District No. ~~[illegible]~~ 6222

2. FULL NAME Tom Walls

(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 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

NOV 29 1932

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
about 69			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartville, Mo

FATHER

13. NAME Bob Walls.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartville Mo

MOTHER

15. MAIDEN NAME Paralee Perkins (Hutchins)

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Manes Mo

17. INFORMANT (ADDRESS) Mrs. Eva Walls Mtn Grove Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Fairview Cem DATE 10-13- 1932

19. UNDERTAKER (ADDRESS) Patterson & Son Mtn Grove Mo

20. FILED 10/13 1932 [illegible] Hubbard Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12 1932

22. I HEREBY CERTIFY, That I attended deceased from 2/10, 1932, to 10/12, 1932

I last saw h... alive on 10/8 1932. Death is said to have occurred on the date stated above, at 6:30 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Paralytic Stroke	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) R. A. Ryan, M. D.

(Address) Mtn Grove

A.B.—Prevention of information should be carefully supplied. Full blanks so that State Board may be able to make use of the information. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

CAUSE OF [illegible] plain terms, so that it ma[illegible] [illegible]ified. Exact statement of OCCUPAT[illegible] [illegible] very important.

REGISTRAR [illegible] RECEIVE A FEE FOR [illegible]ICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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 Wright — Registration District No. 908 — File No.

Township Mt. Grove — Primary Registration District No. 6222 — Registered No. 35

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

2. FULL NAME Tom Walls

(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	M

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.
Abt	69			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

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

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT .....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ....., 19....

19. UNDERTAKER .....
(ADDRESS)

20. FILED 10/13, 1932 J. W. Hubbard
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12, 1932

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Paralysis general	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

(Address) .....

SUPPLEMENTARY

8210

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