

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

SEP 20 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Sup of 26461-39

State File No. 29876

Registration District No. 651

Primary Registration District No. 5863

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Winnemouthe
(b) City or town R.F.D. Little Prairie, Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
(Specify whether _____)

8. (b) IF DECEASED FULL NAME Walter H. Filmore 455

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Oleiver Filman 6. (c) Age of husband or wife 18 years

7. Birth date of deceased Nov. 18 1920
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	8	17	hr. min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name Robert Gates

13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Laura Gates

15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Minnie Filman

(b) Address Caruthersville, Mo.

17. (a) Burial (b) Date thereof Aug. 9, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Cemetery

18. (a) Signature of funeral director H. S. Smith

(b) Address Caruthersville, Mo.

19. (a) Aug. 8, 1939 (b) C. E. Martin
(Date rec'd of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Winnemouthe

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 39 (If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 5 year 1939 hour 11:20 minute 0 P. M.

21. I hereby certify that I attended the deceased from July 1 1938, to Aug. 5 1939; that I last saw her alive on Aug. 16 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Acute
Myocardial Infarction

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

Duration 9
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature O. L. Leguins (M. D. or other)

Address Caruthersville, Mo. Date signed Aug. 7, 1939

RECEIVED

District Health Officer No. 3

District File Number 939-5

Date Filed 9/6/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.