

REC'D OCT 12 1939

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

32537
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 385
(b) Township _____ Primary Registration District No. 4228 Registered No. _____
(c) or City Willow Springs (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred _____ mos. ds. (K) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
William K. Hathaway WALLIN
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Been Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb - 1, 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 7 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as 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) Leuru

13. NAME _____

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

15. MAIDEN NAME Jane Babely

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

17. INFORMANT (ADDRESS) A. J. Hubberts Willow Springs

18. BURIAL, CREMATION, OR REMOVAL PLACE Willow Springs Mo DATE Sept 25 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Burns & Son Willow Springs, Mo

20. FILED 9-25-1939 Marvella Ferguson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 24, 1939

22. I HEREBY CERTIFY That I attended deceased from Sept 23 1939, to Sept 25 1939
I last saw him alive on Sept 23 1939. 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:

Cerebrovascular
Date of onset 9-22-39
Other contributory causes of importance: STV

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) J. C. Cavaler, M. D.
(Address) Willow Springs

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

46
H
O

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 1039 281

Licensed Embalmer No.....

Date Filed 10 6 3 9

P. O. Address.....

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

325-377
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 385
 (b) Township Willow Spring Primary Registration District No. 4228
 (c) City Willow Spring Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Wallin

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widower

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

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

7. AGE YEARS 85 MONTHS 7 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 8-25 1939 Nanette Ferguson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-24-1939

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

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) J. P. Cavallini, M. D.

(Address) Willow Spring Mo

SUPPLEMENTARY

REG. O. 10-1-39 Every item of information on this certificate is prescribed by law.

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE OF TEXAS

Do not use this space.

Registered No. _____

Print name (with its name instead of the local number)
in U.S., if of foreign birth. Sex. Mar. Sta.

City, town and State

OF DEATH

10

of deceased from

10

10