

Registration District No. 561

Primary Registration District No. 4330

Registrar's No.

74

## 1. PLACE OF DEATH:

(a) County Miller 1  
 (b) City or town Eldon  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Eldon Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community Medical WEEK years, months or days)

## 3. (a) PRINT FULL NAME

Not Named Whalen 4503. (b) If veteran,  
name warXX3. (c) Social Security  
No.XX

4. Sex

m5. Color or  
racewhite6. (a) Single, widowed, married,  
divorced5

6. (b) Name of husband or wife

X6. (c) Age of husband or wife if  
alive \_\_\_\_\_ yearsXX

7. Birth date of deceased

Nov 319391939

8. AGE:

Years

XX

Months

X

Days

X

If less than one day

hr. 10 min.

9. Birthplace

Eldon Mo

(City, town, or county)

(State or foreign country)

10. Usual occupation

No report

11. Industry or business

XX0

12. Name

Geo Whalen 0

13. Birthplace

Miller Co Mo

(City, town, or county)

(State or foreign country)

14. Maiden name

Maud Burdette

15. Birthplace

Miller Co Mo

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

Geo W Whalen

(b) Address

St. Elizabeths Mo17. (a) Burial

(b) Date thereof

Nov 4

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Eldon Mo

18. (a) Signature of funeral director

W. A. Phillips

(b) Address

Eldon Mo 46519. (a) 11-4-1939(b) Belle Hamilton

(Date received local registrar)

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day \_\_\_\_\_  
 year 1939 hour 7 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from

\_\_\_\_\_, 19\_\_\_\_, to Nov 3, 1939;that I last saw her alive on Nov 3, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death

asphyxiation

Duration

Due to

exsanguination

Due to

Placenta Praevia

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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 L. M. Haver (M. D. or other) MDAddress Lebanon MoDate signed 11-4-39

RECEIVED

Mi. er County Health Dep't.

County Number 37-140

Date Filed 12-11-39

*not Embalmed*

**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 with the above constitutes grounds for revocation of license.)**

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