

Registration District No. 527

Primary Registration District No. 5703

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Macon 1940  
(a) County Macon  
(b) City or town Bever  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME Willard Willingham  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced M -  
6. (b) Name of husband or wife Mattie Willingham 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 13 - 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
63 6 23 hr. min.

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

10. Usual occupation Railroad switchman

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Wm Willingham  
13. Birthplace Bever Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Mattie Beaton  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mattie Willingham  
(b) Address Bever Mo

17. (a) burial (b) Date thereof Aug 8 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bever Mo

18. (a) Signature of funeral director Edw Simpson  
(b) Address Macon Mo

19. (a) January 13 (b) Edw Simpson  
(Date received local registrar) (Registrar's signature)  
1940

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Macon  
(c) City or town Bever  
(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 Jan day 6  
year 1940 hour 9:30 minute 30 AM.  
21. I hereby certify that I attended the deceased from Nov 7, 1939, to January 6, 1940  
that I last saw him alive on January 5, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease Duration 5 yrs

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Includes pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 A. L. Burden (M. D. or other) MD  
Address Callao Mo Date signed 1/11/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD OF 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.

Rev. 5-17-39  
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RECEIVED FILED WITH OFFICE  
INDEX CARD RETURN TO DISTRICT  
DATE 1-21-61

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**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

*Joseph G. Galt*

Licensed Embalmer No. 4064

P. O. Address Macon, Miss

**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.**