

Registration District No. **66**

Primary Registration District No. **16220B**

Registrar's No. **7**

1. PLACE OF DEATH:
 (a) County Walla Walla
 (b) City or town Wellington Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: none
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no (Specify whether)
 In this community 63 yrs (Specify whether)
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Walla Walla
 (c) City or town Wellington Rural
 (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.? no years.

3. (a) PRINT FULL NAME JAMES MARVIN ALUMBAUGH

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ **3. (c) Social Security** No 497-07-0504

20. DATE OF DEATH: Month Feb day 11th
year 1940 hour 15 minute 30 P.M.

4. Sex Male **5. Color or race** white
6. (a) Name of husband or wife Chinook **6. (b) Age of husband or wife if**
Alumbaugh 57 years
7. Birth date of deceased Mar 4 1976
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-11
7-11 1940, to Feb 11th 1940,
that I last saw him alive on Feb 11th 1940,
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>9</u>	<u>7</u>	

Immediate cause of death Broncho-Pneumonia
following Influenza

9. Birthplace: Odessa Mo. O
(City, town, or county) (State or foreign country)

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation Miner

Major findings: _____
Of operations _____

11. Industry or business Coal miner
12. Name Isaac Porter Alumbaugh
13. Birthplace Odessa Mo. O
 (City, town, or county) (State or foreign country)

Of autopsy _____

14. Maiden name Ella Nicholson
15. Birthplace Odessa Mo. O
 (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mrs. Eileen Alumbaugh
(b) Address Wellington, Mo.

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

17. (a) Burial (Burial, cremation, or removal) Burial
 (b) Date thereof Feb 14 1940 (Month) (Day) (Year)
 (c) Place: burial or cremation Arnold Cemetery, Wellington, Mo.

23. Signature R. B. Watts (M. D. or other) MD
Address Wellington Mo Date signed 2-12-40

18. (a) Signature of funeral director St. Owen
 (b) Address Wellington, Mo.
19. (a) _____ (b) F. W. Morris
 (Dated received local registrar) (Registrar's signature)

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,
District File Number
3/8/40
Date Filed

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 *D. J. Jones*

Licensed Embalmer No. *3070*

P. O. Address *Wellington, Va*

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.