

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10562

Registration District No. 135

Primary Registration District No. 4080

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Carroll  
(b) City or town Wakonda  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Fred Logan Walters 362

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 5 24 1903  
(Month) (Day) (Year)

8. AGE: Years 36 Months 10 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Carroll Co Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

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

MOTHER FATHER { 12. Name John Walters  
13. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Estley Thomas  
15. Birthplace Carroll Co Carolina  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Martha Walters

(b) Address Wakonda Mo

17. (a) Burial (b) Date thereof 3/27/1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adkins Cem

18. (a) Signature of funeral director Willsie Marshall 130  
(b) Address Carroll Mo (Specify type of place)

19. (a) 3/27-40 (b) Paul Hashina  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll  
(c) City or town Wakonda Mo  
(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 3 day 25  
year 1940 hour 11 minute 25 P.M.

21. I hereby certify that I attended the deceased from Jan. 1, 1940, to Mar. 3, 1940,  
that I last saw him alive on Mar. 1, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death acute Rheumatic fever ?

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

Other conditions Sub. Infection ?  
(Include pregnancy within 3 months of death)

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

130 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. Hamilton Stuber (M. D. or other) W.H.  
Address Carroll Mo Date signed Mar 26 Pa.

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

7  
8  
0

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed N-10-11

**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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed R. M. Marshall

Licensed Embalmer No. 2825

P. O. Address Cancelled

**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.