

N. B.—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.

NOV 25 1940

Registration District No. **479**

Primary Registration District No. **3025**

Registrar's No. **87**

1. PLACE OF DEATH:  
 (a) County Linn  
 (b) City or town Brookfield  
 (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 JENETTE ALENE WALTERS  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased October 25 1940  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 1 hr. 15 min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER  
 { 12. Name Robert G. Walters  
 { 13. Birthplace North Salem Mo.  
 { 14. Maiden name Genevieve R. Barker  
 { 15. Birthplace Marceline Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert G. Walters  
 (b) Address Brookfield Mo.

17. (a) Burial (b) Date thereof Oct-26-1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Cave Hill

18. (a) Signature of funeral director Will Funeral Chapel  
 (b) Address Brookfield Mo.

19. (a) Oct 26 40 (b) [Signature]  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. 617 Snow St (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct day 25  
 year 1940 hour 5:45 minute \_\_\_\_\_ P. M.  
 21. I hereby certify that I attended the deceased from Oct 25  
 \_\_\_\_\_, 1940, to Oct 25, 1940  
 that I last saw him alive on Oct 25, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 8 months of death) \_\_\_\_\_

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

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?  
445 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature H. H. Potts (M. D. or other) \_\_\_\_\_  
 Address Brookfield Mo. Date signed Oct 26, 40

Duration 50 min  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

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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.....

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.**