

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

Registration District No. **645**

Primary Registration District No. **5854**

Registrar's No. **4**

1. PLACE OF DEATH:

(a) County **Ozark**
 (b) City or town **Mammoth**
(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
 In this community **15 months** (Specify whether years, months or days)

8. (a) PRINT FULL NAME **Frank Walroth**

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

4. Sex **M** 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 alive years

7. Birth date of deceased **December 7 39**
(Month) (Day) (Year)

8. AGE: Years **1** Months **35** Days **13** If less than one day **hr. min.**

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

10. Usual occupation **Farming**

11. Industry or business

MOTHER FATHER { 12. Name **Richard Walroth**
 13. Birthplace **Mammoth Mo**
(City, town, or county) (State or foreign country)
 14. Maiden name **Opie Rhamy**
 16. Birthplace **Mammoth Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **D. E. Rhamy**
 (b) Address **Mammoth Mo**

17. (a) **Burial** (b) Date thereof **March 21 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Mammoth Cemetery**

18. (a) Signature of funeral director **Clint King**
 (b) Address **Gaineville Mo**

19. (a) **3-21-41** (b) **J. T. White**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ozark**
 (c) City or town **Mammoth Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **0**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **20**
 year **1941** hour **10** minute **0** M.

21. I hereby certify that I attended the deceased from **March 17**
 19**41**, to **March 20**, 19**41**
 that I last saw him alive on **10 PM, 3-19-**, 19**41**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Dilation of Stomach**
 Due to **Pneumonia**
 Duration **12 Hr**

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

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? **578**
(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)
 Means of injury **2**
 23. Signature **M J Voeyman** or other **20**
 Address **Gaineville** Date signed **MO**

RECEIVED

District Health Officer No. 8

District File Number 441-537

Date Filed APR 4 1947

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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 A. B. Hutchison

Licensed Embalmer No. 3431

P. O. Address Geneville MO

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11569

Registration District No. 645

Primary Registration District No. 5854

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Osage
(b) City or town Bridges Twp
(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 Frank Walrath

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 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 alive _____ year _____

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days 13 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2d
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of stomach Duration _____

Due to bronchial pneumonia

Due to no complications

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 107

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) (c) Means of injury _____

23. Signature M. J. Hoeman M.D.

Address _____ Date signed _____

SUPPLEMENTAL

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

MOTHER FATHER

11569

Cal. J. 11569