

21247

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 15 1942

Registration District No. 325

Primary Registration District No. 5450

Registrar's No. 93

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Walnut Grove
(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 15 years _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene ³⁹

(c) City or town Walnut Grove
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Arena A. Willard

3. (b) If veteran, name war WW

3. (c) Social Security No. 70

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John C. Willard

6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased August 12 1844
(Month) (Day) (Year)

8. AGE: Years 97 Months 7 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name John Hampton

13. Birthplace Va. 1
(City, town, or county) (State or foreign country)

14. Maiden name Parlina Manning

15. Birthplace Va. 1
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Willard

(b) Address Walnut Grove, Mo.

17. (a) Burial (b) Date thereof June 1 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove Cemetery

18. (a) Signature of funeral director Small Brim

(b) Address Walnut Grove, Mo.

19. (a) 30/42 (b) Nelson L. Murray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1942 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from May 1
1940, to May 29 1942

that I last saw her alive on May 29 1942
and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia (hypostatic) Duration _____

Due to apoplexy

Due to _____

Other conditions _____
(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? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature W. R. Dawn D.O. (M.D. or other) _____

Address Walnut Grove Date signed 5/29/42

1245 (Licensed Emballer's Statement on Reverse Side)

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

241139
29484

RECEIVED

Greene County Health Office,

County File Number 42-7-59

Date Filed 1/8/42

0242

E.V.

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 J. A. Birch
Licensed Embalmer No. 3856
P. O. Address Ash Grove 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21247

Registration District No. 325

Primary Registration District No. 5450

Registrar's No. _____

1. PLACE OF DEATH: Greene Rural

(a) County Greene

(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Phena A Willard

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

4. Sex 71 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Aug 12 1849
(Month) (Day) (Year)

8. AGE: Years 97 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER { 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 May day _____ year 1942 hour _____ minute _____ M.

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

Immediate cause of death _____

Pneumonia

Due to _____

Due to _____

Other conditions _____
(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? _____

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

23. Signature W. R. Davi (M. D. or other) _____
Address Madison Ave Date signed 8/7/42

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

SUPPLEMENTARY

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100