

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 40

1. PLACE OF DEATH:

(a) County FRANKLIN
(b) City or town SULLIVAN
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
NORTHSIDE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME WILLIAM RILEY WALLS

3. (b) If veteran, name war NONE 3. (c) Social Security No. 499-26-0009

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 3 divorced

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

7. Birth date of deceased February 12 1898
(Month) (Day) (Year)

8. AGE: Years 45 Months 10 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business Laborer "Common"

12. Name LOUIS D. WALLS

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

14. Maiden name MARY V. PARSONS

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

16. (a) Informant Mont. Walls
(b) Address 13229 Bradley St. St. Louis Mo

17. (a) Burial (b) Date thereof 11 6 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads Leasburg Mo
18. (a) Signature of funeral director Chas. V. Walker
(b) Address Sullivan Mo

19. (a) Jan 5/44 (b) Silbert Gilhaus
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 4
year 1944 hour 20 minute A M.

21. I hereby certify that I attended the deceased from December 30th
January 3rd., 1944, to January 3rd., 1944;

that I last saw him alive on January 3rd., 1944;

and that death occurred on the date and hour stated above.

Immediate cause of death Dober Pneumonia

Due to _____

Due to _____

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

Major findings: 108

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

23. Signature Samuel R. Raymond (M. D. or other) 1/5/43
Address Sullivan, Mo. Date signed _____

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

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 Edgar W. Laffoon

Licensed Embalmer No. 13394

P. O. Address Sullivan 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.