

FILED JUN 5 1944

Primary Registration District No. 3026

Registrar's No. 30

1. PLACE OF DEATH:  
**Stoddard**  
(a) County Stoddard  
(b) City or town Dexter  
(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 Walter R. Wilmoth  
3. (b) If veteran, name war.....  
3. (c) Social Security No. 497-09-1526

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife Goldie Wilmoth  
6. (c) Age of husband or wife if alive 45 years  
7. Birth date of deceased January 10, 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 4 11 hr. min.

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

10. Usual occupation Mill worker

11. Industry or business I. X. L. Handle Co.

MOTHER FATHER {  
12. Name John Wilmoth  
13. Birthplace Baxter Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name No. Record  
15. Birthplace No. Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Hubert Wilmoth  
(b) Address Memphis, Tenn.

17. (a) Burial (b) Date thereof 5-22-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chapel Hill Cemetery

18. (a) Signature of funeral director Blankenship-Strickland  
(b) Address Dexter, Mo.

19. (a) 5-23-44 (b) Noaa Smith  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Stoddard  
(c) City or town Dexter  
(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 21  
year 1944 hour 3 minute 0 A. 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 Suffocation

Due to.....  
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....  
Of autopsy.....  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence May 21, 1944

(c) Where did injury occur? Dexter Stoddard Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public place  
While at work?..... (Specify type of place)  
(e) Means of injury.....

23. Signature Chloeyane, act, error (M. D. or other)  
Address Dexter, Mo. Date signed 5/23/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June  
Registrar's No. 20

Registration District No. 341

Primary Registration District No. 3075

1. PLACE OF DEATH: Stoddard  
(a) County.....  
(b) City or town.....  
(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 Walter R. Welmoth  
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 m  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased: Jan 10 (Month) (Day) (Year)

8. AGE: Years 60 Months 4 Days 10 If less than one day..... min.

9. Birthplace Ill. (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) (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 12 year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death asphyxiation Duration

Due to.....  
Due to..... 182'2"  
Other conditions..... (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION  
Major findings: 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) asphyxiation caused by burning matrix, ignited by him  
(b) Date of occurrence.....  
(c) Where did injury occur? Dexter Stoddard, MO  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? in City Jail, while intoxicated  
While at work?..... (Specify type of place) (e) Means of injury.....  
23. Signature W. R. Welmoth, et al, (M. D. or other)  
Address Dexter, Mo Date signed.....

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

SUPPLEMENTARY INFORMATION

19299

ADMINISTRATIVE SERVICE  
DIVISION

1944 JUN 10 PM 1 39

BUREAU OF CENSUS