

FILED SEP 6 1944
Registration District No. **144**

Primary Registration District No. **4234**

Registrar's No. **27**

1. PLACE OF DEATH:

(a) County **Iron**
(b) City or town **Ironton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Mary's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **11 days**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Reynolds**
(c) City or town **Lesterville**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Walker Thomas Pine**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **m** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**

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

7. Birth date of deceased **December 11 1902**
(Month) (Day) (Year)

8. AGE: Years **41** Months **8** Days **9** If less than one day _____ hr. _____ min.

9. Birthplace **Chicago Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business _____

12. Name **Jonathan R. Pine**

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

14. Maiden name **Margarette Lillie Walker**

15. Birthplace **Chicago Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lillie Pine**

(b) Address **Lesterville Mo.**

17. (a) **removal** (b) Date thereof **8-21-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chicago Illinois**

18. (a) Signature of funeral director **Norman White & Sons**

(b) Address **Ironton Mo.**

19. (a) **Aug 23, 1944** (b) **Dr. Francis C. Howard**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **20th**
year **1944**, hour **12:00** minute **20.0** N

21. I hereby certify that I attended the deceased from **Aug 8th**
1944 to **Aug 20th 1944**
that I last saw **alive on Aug 19th 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
acute bronchial pneumonia --- 8/19/44

Due to **acute Dysentery (flexor type)** --- 7/15/44

Due to **Secondary anaemia** ?

Other conditions _____
(Include pregnancy within 3 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **P. E. Farland** (M. D. or other) **Dr.**

Address **Ironton, Mo.** Date signed **8/20/44**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4
District File Number 944-4248
Date Filed 9-5-44

5 1945

APR

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 Amel J. White

Licensed Embalmer No. 3072

P. O. Address Smith Ave

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.