

FILED MAR 8 1945

State File No. _____
Registrar's No. 16

Registration District No. 47

Primary Registration District No. 3008

1. PLACE OF DEATH:
(a) County: Callaway
(b) City or town: Fulton
(c) Name of hospital or institution: State Hospital No. 12
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 yrs 4m 8d
(Specify whether years, months or days) 11 yrs 4m 8d

2. USUAL RESIDENCE OF DECEASED:
(a) State: Massachusetts (b) County: Cheriton
(c) City or town: Salisbury (If outside city or town limits, write "RURAL")
(d) Street No.: County Ins. Agency (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Ella Wallington
(b) If veteran, name war: D.K.
(c) Social Security No.: D.K.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 13 year 1945 hour 1-30 minute 2 M.
21. I hereby certify that I attended the deceased from 1-10-1945 to 1-13-1945 that I last saw him alive on 1-12-1945 and that death occurred on the date and hour stated above.

4. Sex: Female 5. Color or race: Negro
6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive: _____ years

Immediate cause of death: Myocarditis
Due to: _____
Due to: Arteriosclerosis
Other conditions (Include pregnancy within 3 months of death): _____

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>			hr. _____ min.

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

10. Usual occupation: None

11. Industry or business: _____

MOTHER FATHER

12. Name: ST
13. Birthplace: ST (City, town, or county) 9 (State or foreign country)
14. Maiden name: ST
15. Birthplace: ST (City, town, or county) 9 (State or foreign country)

16. (a) Informant: Record
(b) Address: _____

17. (a) Removal (b) Date thereof: 1 17 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Columbia Md

18. (a) Signature of funeral director: E. O. Roberts
(b) Address: Columbia Md

19. (a) 1-17-1945 (b) Josie Moravkoff
(Date received local registrar) (Registrar's signature)

Major findings: _____
Of operations: AB
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) _____
Means of injury: _____
23. Signature: George H. Reus (M. D. or other) MS
Address: Fulton Ma Date signed: 1-13-45

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

14
1
2

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed 3-7-45

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.