

**FILED** <sup>294</sup>  
**NOV 28 1945**

Registration District No. 2

Primary Registration District No. 294 3056

Registrar's No. 190

1. PLACE OF DEATH:

(a) County Randolph  
(b) City or town Moberly  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
519 Fort St. /  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph  
(c) City or town Moberly  
(If outside city or town limits, write "RURAL")  
(d) Street No. 519 Fort St. 3  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Eva Walden

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

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Alex 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec. 25 1858  
(Month) (Day) (Year)

8. AGE: Years 86 Months 9 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At home

11. Industry or business

12. Name William S. Christian

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

14. Maiden name Mary E. Terrill

15. Birthplace Ky /  
(City, town, or county) (State or foreign country)

16. (a) Informant James Austin Walden

(b) Address Moberly Mo

17. (a) Burial (b) Date thereof Oct 12 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Mo

18. (a) Signature of funeral director Malcolm Anderson

(b) Address Moberly Mo

19. (a) 10-12-45 (b) Leah Williams  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11<sup>th</sup>  
year 1945 hour \_\_\_\_\_ minute 20 A.M.

21. I hereby certify that I attended the deceased from Oct 7 1945 to Oct 11 1945

that I last saw him alive on Oct 10 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage

Due to Hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: (b) (c)

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 0

23. Signature Shelley H. H. H. (M. D. or other) \_\_\_\_\_

Address Moberly Mo Date signed 10-12-45

Duration

1 week

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1601

RECEIVED

District Health Officer No. 10

District File Number 11-45-1664

Date Filed NOV 23 1949

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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 Frank J. Witt

Licensed Embalmer No. 3021

P. O. Address Moberly 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.