

FILED FEB 13 1947

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **574**

1. PLACE OF DEATH:

(a) County **Callaway**

(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
State Hospital No 1. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **9 years.**
(Specify whether)

In this community **same**
years, months or days

3. (a) PRINT FULL NAME **William J. Whalen.**

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

4. Sex **M. C.** **5. Color or race** **W**

6. (a) Single, widowed, married, divorced **S. O.**

6. (c) Age of husband or wife if **21** **1899**
alive _____ years
(Month) (Day) (Year)

7. Birth date of deceased **6** **21** **1899**
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| 48 | 5 | 13 | _____ hr. _____ min. |

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

10. Usual occupation **laborer**

11. Industry or business

12. Name **Bernard Whalen**

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

14. Maiden name **Haura Gules**

15. Birthplace **St Louis County**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Records**

(b) Address **Fulton Mo.**

17. (a) Removal **(b) Date thereof** **24-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mexico Mex**

18. (a) Signature of funeral director **Earl E. Pugh**

(b) Address **Mexico Mex**

19. (a) Feb 4-1947 **(b) Josie Moravichoff**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Andrew**

(c) City or town **Mexico**
(If outside city or town limits, write "RURAL")

(d) Street No. **Bushman**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **4**
year **1947** hour **9** minute **17** M.

21. I hereby certify that I attended the deceased from **1-3-47**, 19____, to **2-4-47**, 19____;
that I last saw him alive on **2-4-47**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis.**

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration

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) _____

(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)

(c) Means of injury _____

23. Signature **R. P. Price M.D.** (M. D. or other)

Address **Fulton Mo.** **Date signed** **2-4-47**

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

14
1/2

MOTHER FATHER

38
by K. Mayo.

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 2-11-47

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 Carl E. Prueh

Licensed Embalmer No. 3189

P. O. Address Mexico 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.