

No. 2
1-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **888**
Registration District No. **133** Primary Registration District No. **3-0225500** Registrar's No. **1**

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

1. PLACE OF DEATH:
(a) County **Harrison**
(b) City or town **Rural Union Twp**
(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 **that all of life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Edgar Barnes Walradt**
3. (b) If veteran, name war **L** 3. (c) Social Security No.

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Mary Ann Walradt** 6. (c) Age of husband or wife if alive **84** years
7. Birth date of deceased: **Aug 8 1864**
(Month) (Day) (Year)

8. AGE: Years **82** Months **4** Days **23** If less than one day hr. min.

9. Birthplace **Cass Co. Nebr. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business

MOTHER FATHER
12. Name **Isaac Walradt**
13. Birthplace **N.Y. 1**
14. Maiden name **Delphia Bilant**
15. Birthplace **N.Y. 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bert Pancher**
(b) Address **Rayway Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Jan 26 1947**
(Month) (Day) (Year)

(c) Place: burial or cremation **Allen Cemetery**

18. (a) Signature of funeral director **Joe E. Wheeler**
(b) Address **Rayway Mo**

19. (a) **Jan. 4-47** (Date received local registrar) (b) **John Burres** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Harrison 4**
(c) City or town **Rural** (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 **Jan** day **1** year **1947** hour **3** minute **30 AM**

21. I hereby certify that I attended the deceased from **11-27 1946** to **Jan 1 1947**
that I last saw him alive on **12-19-1946** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis -**

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **A3D**
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 **W. S. Broyle** (M. D. or other) Address **Rayway Mo** Date signed **1-4-47**

Duration **3 1/2**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Joe E. Wheeler
Licensed Embalmer No. 3512
P. O. Address Bithany 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.