No. 2
-12-45
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 25 1947

Registration District No. 728

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5466

State File No. 27471

Registrar's No. 689

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield - Rural S. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ozark Osteopathic Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 74 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Greene
(c) City or town: Springfield Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 2700 W. Water St.,
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Carl Mar Waltz.

3. (b) If veteran, name war: None

3. (c) Social Security No. None

4. Sex: Male

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 (Month) 25, (Day) 1872 (Year)

8. AGE:

Years	Months	Days	If less than one day
74	7	6	hr. min.

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

10. Usual occupation: Retired Carpenter

11. Industry or business: Carpentering

FATHER
12. Name: Elias Waltz
13. Birthplace: Ohio. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Helen M. Brittian
15. Birthplace: Ill. (City, town, or county) (State or foreign country)

16. (a) Informant: Miss Edna Waltz,
(b) Address: Branson Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-3-1947. (Month) (Day) (Year)
(c) Place: burial or cremation: Bolivar Mo.

18. (a) Signature of funeral director: J. W. Klingner & Co.
(b) Address: Springfield Mo.

19. (a) 8-2-47 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 1, year: 1947 hour: 2 minute: 25 P. M.

21. I hereby certify that I attended the deceased from July 27, 1947, to Aug. 2, 1947, that I last saw him alive on Aug 2, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days

Due to

Due to

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

Major findings:
Of operations

Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: E. A. Wilson (M. D. or other) M.D.
Address: Springfield Mo. Date signed: Aug 2, 47

(Licensed Embalmer's Statement on Reverse Side)

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 Ogle Slone Jr

Licensed Embalmer No. 4126

P. O. Address Springfield

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.