

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37410**

FILED DEC 12 1947
Registration District No. **64**

Primary Registration District No. **5244**

Registrar's No. **67**

1. PLACE OF DEATH:

(a) County **Chariton**
(b) City or town **Rural Cockrell Township**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
North east of Eccles 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Walter Roosevelt Draper**

3. (b) If veteran, name war **1st World War** 3. (c) Social Security No. **1**

4. Sex **male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Aug 31 1898**
(Month) (Day) (Year)

8. AGE: Years **49** Months **2** Days **20** If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **John Draper**

13. Birthplace _____ (City, town, or county) (State or foreign country) **Ill**

14. Maiden name _____ (City, town, or county) (State or foreign country) **un known**

15. Birthplace _____ (City, town, or county) (State or foreign country) **Ireland**

16. (a) Informant's own signature **Henry Bertsch**

(b) Address **Salisbury Mo**

17. (a) **Burial** (b) Date thereof **11 23 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Salisbury City Cem**

18. (a) Signature of funeral director **W. B. Winkelman**

(b) Address **Salisbury Mo**

19. (a) **11/21/47** (b) **W. B. Winkelman**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Chariton**
(c) City or town **rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **North east of Eccles**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **21st**
year **1947** hour **1:01** minute **52** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to **Traumatic or Personal cause had recurrence**

Due to **Regularly**

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

Major findings: 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 _____

23. Signature **W. B. Winkelman** (M. D. or other) _____

Address **Meriden Mo** Date signed **11/21/47**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN Underline cause to which death should be charged statistically

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

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-11-47

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.....

Chas B. Winkelman
Licensed Embalmer No. 3842

P. O. Address Salisbury, 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, above space should be left blank.

Registration District No. *64*

Primary Registration District No. *5244*

1. PLACE OF DEATH:

(a) County *Chariton*
 (b) City or town *Rural*
 (If outside city or town limits, write "RURAL" and name of township)
 (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 _____ (Specify whether _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME *Walter R. Diaper*

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

4. Sex *m* 5. Color or race *w* 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *aug 3* (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____ (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 _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to *Blow on the head by the use of clubs.*

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *at accident*

(b) Date of occurrence *Nov. 21 - 1947*

(c) Where did injury occur? *on farm* (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *at home on farm*

While at work? _____ (Specify type of place) (e) Means of injury *Blow on head*

23. Signature *W. D. West* (M. D. or other) *12/15/47*

Address *Medford mo* Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

37410