

FILED JAN 22 1948 2864

Registration District No. \_\_\_\_\_

Primary Registration District No. 4-3-95-111

Registrar's No. 38

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

1. PLACE OF DEATH: Ozark  
(a) County: Rural- Bridges Twp.  
(b) City or town: (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: 5 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME: William G. Valle

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: M O 5. Color or race: W 6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Mary A. Valle 6. (c) Age of husband or wife if alive: 51 years

7. Birth date of deceased: December 1 1880 (Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 14 If less than one day hr. min.

9. Birthplace: Washington Co. Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: \_\_\_\_\_

12. Name: Francis Valle

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

14. Maiden name: unknown

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

16. (a) Informant: \_\_\_\_\_ (b) Address: Gainesville, Mo.

17. (a) Burial (b) Date thereof: 11-18-47 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Clear Springs Cem.

18. (a) Signature of funeral director: Clinkingbeard Funeral Home (b) Address: Gainesville, Missouri

19. (a) Dec. 3, 1947 (b) Pamela Jump (Data received local registrar) (Registrar's signature) 12/5/47

2. USUAL RESIDENCE OF DECEASED: Ozark 73  
(a) State: Missouri (b) County: Ozark  
(c) City or town: Gainesville, rural (If outside city or town limits, write "RURAL")  
(d) Street No.: \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 16 day 8 hour 30 P minute M. year 1947

21. I hereby certify that I attended the deceased from April 1945 to Nov 16 1947 that I last saw him alive on Nov 12 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Cause of death: Lung with Metastasis Duration: 2 yrs

Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_  
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?

23. Signature: \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address: \_\_\_\_\_ Date signed: 11/19/47

PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 148-118

Date Filed 1-19-48

---

---

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 W.B. Hutchison

Licensed Embalmer No. 3431

P. O. Address Gainesville 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.