

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

28-57-88

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26942

FILED SEP 7 1948

Registration District No. 385

Primary Registration District No. 3039

Registrar's No. 185

1. PLACE OF DEATH:

(a) County Rinn

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

(c) Name of hospital or institution:
St Francis
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 weeks
(Specify whether
years, months or days) 69 years

3: (a) PRINT FULL NAME George William Walter

3. (b) If veteran, name war: -

3. (c) Social Security No. -

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife: Mayme Musgrave Walter 6. (c) Age of husband or wife if alive: 41 years

7. Birth date of deceased: July 19 1859
(Month) (Day) (Year)

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

89 0 12 hr. min.

9. Birthplace Howard Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Joseph J. Walter

13. Birthplace Lawrence Co Pa
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Welsh

15. Birthplace Lawrence Co Pa
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Myrl Oldham

(b) Address Marceline Mo

17. (a) Rural (b) Date thereof Aug 2 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem

18. (a) Signature of funeral director James McLaughlin

(b) Address Marceline Mo

19. (a) 4-2-48 (b) Mary J. Dwens
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton

(c) City or town Marceline Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 2 miles South 21
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No) 0

If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1948 hour 5:10 minute 00 AM

21. I hereby certify that I attended the deceased from June 1948
1948 to July 31 1948
that I last saw him alive on July 31 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Cardio-vascular Disease

Due to _____

Due to _____

Other conditions Gangrene Rt Foot
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy gias

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)

(e) Means of injury _____

23. Signature Robert Smith (M. D. or nat.)
Address Marceline, MO Date signed Aug 24 1948

DISTRICT HEALTH OFFICE
Canton, 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 Blanche McLaughlin
Licensed Embalmer No. 1969
P. O. Address. Marceline

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
Registrar's No. 185

Registration District No. 385

Primary Registration District No. 3039

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Marcelina
(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

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 _____

3. (a) PRINT FULL NAME

George W. Walter

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ 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 _____

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 age _____ years

7. Birth date of deceased: July 17 (Month) 19 (Day) 19 (Year)

8. AGE: Years 89 Months _____ Day _____ 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 _____

12. Name _____

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

14. Maiden name _____ (State or foreign country) _____

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) Aug 2-1948 (Date received local registrar) (b) Mary Jean Owens (Registrar's signature)

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)
(e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

1948

S-26942

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