

FILED FEB 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7069

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3071 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>	
c. LENGTH OF STAY (in this place) <u>40 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>334 West Front</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none (Home)</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Charlie</u>	b. (Middle) _____	c. (Last) <u>Walls</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 14 1949</u>
-------------------------------------	---------------------------	-------------------	------------------------	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 15-1873</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired school teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Howard County, Mo.</u>	
					12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	

13a. FATHER'S NAME <u>Steve Walls</u>	13b. MOTHER'S MAIDEN NAME <u>Jeanette David</u>	14. NAME OF HUSBAND OR WIFE <u>Josie Walls, Slater, Mo</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Josie Walls</u>	ADDRESS <u>Slater Mo.</u>
---	--	---	------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u>  <u>4 yrs?</u>  <u>?</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Chronic Myocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Institutional Hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
---	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
--	--	---------------------------

22. I hereby certify that I attended the deceased from Sept 1, 1946 to Feb 14, 1949, that I last saw the deceased alive on Feb 14, 1949, and that death occurred at 335 m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. B. Leetworn M.D.</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Slater Mo</u>	23c. DATE SIGNED <u>2-16-49</u>
--	-------------------------------	----------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2/17/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Glasgow cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Glasgow, Mo.</u>
--	-----------------------------	---	--

DATE REC'D BY LOCAL REG. <u>2-19-49</u>	REGISTRAR'S SIGNATURE <u>Mo. Earl C. Metz</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Brothers - Slater Mo</u>	ADDRESS
--	--	--	---------

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

97

RECEIVED

District Health Officer No. 8;

District File Number.....

Date Filed 2-24-49

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Sam M Hill

Licensed Embalmer No. 1292

P. O. Address State 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.