

FILED JUL 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 18877

BIRTH NO. _____		REG. DIST. NO. <u>55</u>		PRIMARY REG. DIST. NO. <u>3011</u>		Registrar's No. <u>67</u>	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u>		c. LENGTH OF STAY (in this place) <u>2 months</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grace Carter Home</u> <u>520 West 11th. Street!</u>				d. STREET ADDRESS (If rural, give location) <u>113 1/2 South Main Street.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u>		b. (Middle) <u>Walker</u>		c. (Last) <u>Willis</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 18 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>July 17 1874</u>	
9. AGE (In years last birthday) <u>74</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mens Wear</u>		9. AGE (In years last birthday) <u>74</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas E. Willis</u>		13b. MOTHER'S MAIDEN NAME <u>Mollie Lavine Bailey</u>		14. NAME OF HUSBAND OR WIFE <u>Maggie Sugg Willis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Harry Schanz Carrollton Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lymphatic Leukemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						<u>2040</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Was a patient at Ellis Funchel Cancer Hospital Columbia</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Carl H. Reed, M.D.</u>				23b. ADDRESS <u>Carrollton, Mo.</u>		23c. DATE SIGNED <u>6-20-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 21 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>West of Bogard Mo.</u>	
DATE REC'D BY LOCAL REG. <u>6/21/49</u>		REGISTRAR'S SIGNATURE <u>Mrs Herbert Calvert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Marshall F. Home Carrollton Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE CLEARLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
 & Platy Carrollton who is on vacation. Chas. M.D.

RECEIVED JUL 5
District Health Officer No. 8,
District File Number _____
Date Filed 7-14-49

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 _____

working under my personal supervision.

Signed _____
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. 4469

P. O. Address Corvallis

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.