

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. WILSON
State File No. 4550
Registrar's No. 184

No. 300
10-48

FILED FEB 28 1955

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 184

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. LENGTH OF STAY (in this place) <u>7 YRS.</u>	c. CITY OR TOWN <u>SPRINGFIELD</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>427 ILLDEREEN</u>		e. STREET ADDRESS (If rural, give location) <u>427 ILLDEREEN</u> <u>03960</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CHARLES</u>	b. (Middle) <u>V.</u>	c. (Last) <u>WALLAR</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 24 1955</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 1 1884</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SPFLD. ELECTRIC CO.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>McARTHUR, OHIO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>WALLAR</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>ROSE L. WALLAR</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>?</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. ROSE L. WALLAR</u>	ADDRESS <u>SPRINGFIELD, MO.</u>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute circulatory failure.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary occlusion.</u> DUE TO (c) <u>Arteriosclerotic hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>4 yrs</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct. 27, 1952, to Feb. 24, 1955, that I last saw the deceased alive on Feb. 24, 1955, and that death occurred at 5 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Andrew Hunt D.O.</u>	23b. ADDRESS <u>718 Woodruff Bldg Springfield</u>	23c. DATE SIGNED <u>2/25/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>2/26/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FOREST PARK</u>	24d. LOCATION (City, town, or county) (State) <u>JOPLIN, MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>2-25-55</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Williamson</u>	ADDRESS <u>SPRINGFIELD, MO</u>
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

JUL 7 1955

MAR 27 1956

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.....
Signature of Student Embalmer

Signed *Walter E Hamilton*

Licensed Embalmer No.....3808

P. O. Address SPRINGFIELD, R

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.