. S. No. 2
OM—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 13 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10197

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1005

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community 5 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Slater 97
(c) City or town Saline Co. 2
(If outside city or town limits, write "RURAL") 1
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME William Woods Walden

3. (b) If veteran, name war no

3. (c) Social Security No. 709-10-9620

4. Sex male

5. Color or race white 0

6. (a) ~~Single, widowed,~~ married, ~~divorced~~ married 1

6. (b) Name of ~~husband or~~ wife Hazel Walden

6. (c) Age of ~~husband or~~ wife if alive 44 years

7. Birth date of deceased Oct. (Month) 17 (Day) 1886 (Year)

8. AGE: Years 57 Months 4 Days 14 If less than one day hr. min.

9. Birthplace Hale (~~City, town, or county~~) Mo. 0 (State ~~or foreign country~~)

10. Usual occupation Locomotive engineer

11. Industry or business

FATHER
12. Name Jesse Walden
13. Birthplace (~~City, town, or county~~) Mo. 0 (State ~~or foreign country~~)

MOTHER
14. Maiden name Belle Campbell
15. Birthplace (~~City, town, or county~~) Mo. 0 (State ~~or foreign country~~)

16. (a) Informant Mrs. W.W. Walden
(b) Address Slater, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 3/3/'44 (Month) (Day) (Year)
(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director Sheil Funeral Home
(b) Address K.C.Mo.

19. (a) 3-2-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st year 1944 hour 3 minute a M.

21. I hereby certify that I attended the deceased from 2/26-44, 19, to 3-1-44, 19; that I last saw him alive on 3/1-44, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Peritonitis	
Due to Ruptured Cecal carcinoma = recto	
Due to Sigmoidal puncture	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy no 46e

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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Walter Holbrook (M. D. or other)
Address 1132 Prof Bldg Date ~~signed~~ 3/2/44

(Licensed Embalmer's Statement on Reverse Side)

Vi 4238

Dr. Walter Holbrook
Professional Bldg

11-12 and 1-3

MAR 14 1946

OCT 18 1957

APR 3 1944

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 13 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10197

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1005

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5 days (Specify whether years, months or days)
In this community: 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Slater 97
(c) City or town: Saline Co. 2
(If outside city or town limits, write "RURAL") 1
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

3. (a) PRINT FULL NAME: William Woods Walden
3. (b) If veteran, name war: no
3. (c) Social Security No. 709-10-9620

4. Sex: male
5. Color or race: white
6. (a) ~~Single, widowed, divorced~~ married: /
6. (b) Name of ~~husband or~~ wife: Hazel Walden
6. (c) Age of ~~husband or~~ wife if alive: 44 years
7. Birth date of deceased: Oct. (Month) 17 (Day) 1886 (Year)

8. AGE: Years 57 Months 4 Days 14 If less than one day ___ hr. ___ min.

9. Birthplace: Hale (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Locomotive engineer
11. Industry or business:
FATHER
12. Name: ~~Jesse Walden~~ = Lewis Walden
13. Birthplace: Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Belle Campbell
15. Birthplace: Mo. (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. W.W. Walden
(b) Address: Slater, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 3/3/'44 (Month) (Day) (Year)
(c) Place: burial or cremation: Slater, Mo.
18. (a) Signature of funeral director: Shell Funeral Home
(b) Address: K.C. Mo.
19. (a) 3-2-44 (Date received local registrar) (b) D. C. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st year 1944 hour 3 minute a M.

21. I hereby certify that I attended the deceased from 2/26-44, 19__, to 3-1-44, 19__; that I last saw him alive on 3/1-44, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebritis	
Due to: Ruptured Basal Cardiac = recto	
Due to: Disseminated pneumonia	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: no	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Felix Heilbrook (M. D. or other)
Address: 132 Ward Bldg. Date signed: 3/2/44

(Licensed Embalmer's Statement on Reverse Side)

Item #12 amended by affidavit of daughter and verified by 1880 census

1/26-90