

FILED MAY 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16200
State File No. 1870

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 54 yrs		d. STREET ADDRESS (If rural, give location) 4533 Wornall Road	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4533 Wornall Road			

3. NAME OF DECEASED (Type or Print)	a. (First) MRS. MARY ANN	b. (Middle)	c. (Last) WALTER	4. DATE OF DEATH (Month) (Day) (Year) April 27 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan 24 1857	9. AGE (in years last birthday) 92	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cambridge Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Michael O'Toole	13b. MOTHER'S MAIDEN NAME Ann Brady	14. NAME OF HUSBAND OR WIFE Joseph Walter
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Celia Walter	ADDRESS 4533 Wornall Road
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) M	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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> 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 4/18, 1949 to 4/27, 1949, that I last saw the deceased alive on 4/27, 1949, and that death occurred at 12:15 pm., from the causes and on the date stated above.

23a. SIGNATURE C.G. Leitch M.D.	(Degree or title)	23b. ADDRESS 1109 Pry Bldg. KO Mo	23c. DATE SIGNED 4/28/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/30/49	24c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City Missouri
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DATE REC'D BY LOCAL REG. 4-28-49	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Guirke & Sobin	ADDRESS 20 West Linwood
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Celia Walter

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Maudie Adair

Licensed Embalmer No. 4016

P. O. Address R. O. M.

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.