FILED OCT 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30640

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4137

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 29 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 2712 E. 33rd St.

3. NAME OF DECEASED (Type or Print)
a. (First): Henry
b. (Middle): Ernest
c. (Last): Walz

4. DATE OF DEATH (Month) Sept. (Day) 24 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 13, 1885
9. AGE (In years last birthday): 64 — If under 1 year: Months ___ Days ___ If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker
10b. KIND OF BUSINESS OR INDUSTRY: Wagner Pie shop
11. BIRTHPLACE (State or foreign country): Worth, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Ernest Walz
13b. MOTHER'S MAIDEN NAME: Elizabeth Sicking
14. NAME OF HUSBAND OR WIFE: Dora C. Walz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 486-03-5886
17. INFORMANT'S SIGNATURE OR NAME: Dora C. Walz
ADDRESS: 2712 E. 33rd St.

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myelogenous leucemia

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 2041
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-19, 1949, *to* 9-24, 1949, *that I last saw the deceased alive on* 9-24, 1949, *and that death occurred at* 5:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Jos. W. Parker, Jr. (Degree or title) M.D.
23b. ADDRESS 2603 E 31st KCMo
23c. DATE SIGNED 9-25-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE 9-27-49
24c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24d. LOCATION (City, town, or county) (State): Kansas City Mo.

DATE REC'D BY LOCAL REG. 9-26-49
REGISTRAR'S SIGNATURE Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Mellody-McGilley-Eylar Kansas City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Licensed Embalmer No. 2889

P. O. Address KC

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.