

FILED OCT 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31184

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 245 PRIMARY REG. DIST. NO. 3047 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Newton</u>		2. USUAL RESIDENCE (Where deceased lived. * If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>	
b. CITY OR TOWN <u>Neosho</u>		c. CITY OR TOWN <u>Neosho</u>	
c. LENGTH OF STAY (in this place) <u>Home</u>		73	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home 911 Randolph</u>		d. STREET ADDRESS (If rural, give location) <u>911 RANDOLPH ST 2</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>WALTER</u>	b. (Middle) <u>LAYTON</u>	c. (Last) <u>GUEST</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 18-1949</u>
-------------------------------------	--------------------------	---------------------------	------------------------	---

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>APRIL 30-18-78</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PET MILK COND.</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>

13a. FATHER'S NAME <u>William Franklin</u>	13b. MOTHER'S MAIDEN NAME <u>MARTHA GARNER</u>	14. NAME OF HUSBAND OR WIFE <u>CORNELIA 911 Randolph</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Cornelia Guest</u> ADDRESS <u>Neosho, Mo.</u>
--	-------------------------------	--

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Valvular Heart Disease</u>		
	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.		4214	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 Jan, 1943, to Sept 18, 1949, that I last saw the deceased alive on Sept 17, 1949, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>W. Reynolds M.D.</u> (Degree or title)	23b. ADDRESS <u>Neosho Mo.</u>	23c. DATE SIGNED <u>9-19-49</u>
--	--------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>SEPT. 21-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>DICE CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>Fairview, MO.</u>
---	------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>Sept 24, 1949</u>	REGISTRAR'S SIGNATURE <u>William C. Roseman</u>	223	25. FUNERAL DIRECTOR'S SIGNATURE <u>CLARK-RICHMAN MORTUARY</u> ADDRESS <u>Neosho</u>
---	---	-----	--

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. NEWTON Co. HEALTH UNIT
District File Number 949-167
Date Filed OCT 1 1949

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 H. G. White

Licensed Embalmer No. 4240

P. O. Address Neosho, Mo.

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

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