

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40078

State File No.

FILED DEC 21 1949

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

| | | | | | | | |
|---|--|---|--|---|---|--|---|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. <u>5094</u> | | Registrar's No. <u>363</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>Adair</u> b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Rural--Ninevah Twp.</u> c. LENGTH OF STAY (in this place) <u>75 yrs.</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home--5 miles North Novinger</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural--Ninevah Twp.</u> d. STREET ADDRESS (If rural, give location) <u>5 miles North of Novinger</u> | | | |
| 3. NAME OF DECEASED a. (First) <u>Florence</u> b. (Middle) <u>Victoria</u> c. (Last) <u>Walters</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>December 14, 1949</u> | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>Sept. 11, 1874</u> | |
| 9. AGE (In years last birthday) <u>75</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 1 HR. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>Patrick Dolan</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Malina Workman</u> | | 14. NAME OF HUSBAND OR WIFE <u>William T. Walters</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Sarah Rees Novinger</u> | | ADDRESS <u>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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO b) <u>Chronic Heart Disease</u> 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 <u>36 hr</u> <u>5 yrs</u> <u>331X</u> | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION <u>None</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (as to 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 <u>Oct 13, 1949</u> , to <u>Nov 14, 1949</u> , that I last saw the deceased alive on <u>Dec 13, 1949</u> , and that death occurred at <u>3:00</u> m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Name or title) <u>H. T. Harrison M.D.</u> | | | | 23b. ADDRESS <u>Novinger Mo</u> | | 23c. DATE SIGNED <u>12-14-49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>12-17-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>McGrew Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Adair County, Missouri</u> | |
| DATE REC'D BY LOCAL REG. <u>12-17-49</u> | | REGISTRAR'S SIGNATURE <u>Kate Lambert</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn E. Fent & Son Creators, Mo</u> ADDRESS _____ | | | |

RECEIVED DEC 19 1909
District Health Officer No.
District File Number 12-471
Date Filed DEC 19 1909

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 _____

Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, Mo.

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.