

FILED DEC 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36479

BIRTH NO. _____ REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015 Registrar's No. 86

1. PLACE OF DEATH a. COUNTY CLINTON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CLINTON	
b. CITY (If outside corporate limits, write RURAL and give township) CAMERON		c. CITY (If outside corporate limits, write RURAL and give township) LATHROP RURAL 02-5-13	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION MRS. HANCOY PARTON HOME			

3. NAME OF DECEASED (Type or Print)	a. (First) Serepta	b. (Middle) ANN	c. (Last) WALKER	4. DATE OF DEATH (Month) (Day) (Year) Nov. 21. 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH MAR. 19. 1859	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR Months Days	IF UNDER 12 mos. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) BUGHENNON MO MO	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME POTTER James Edredge	13b. MOTHER'S MAIDEN NAME Mary Wills	14. NAME OF HUSBAND OR WIFE deceased
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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. NO	17. INFORMANT'S SIGNATURE OR NAME NINCOBY WALKER	ADDRESS LATHROP MO
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH 20 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis		20 years
	DUE TO (c) senility		20 years
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia		7 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 4921
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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 **5-24**, 19**50**, to **11-21**, 19**50**, that I last saw the deceased alive on **11-21**, 19**50**, and that death occurred at **10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) G. Hetherington MD	23b. ADDRESS Cameron Mo	23c. DATE SIGNED 11-25-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE Nov. 24. 1950	24c. NAME OF CEMETERY OR CREMATORY LATHROP CEMETERY	24d. LOCATION (City, town, or county) (State) LATHROP MO
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DATE REC'D BY LOCAL REG. 11-25-50	REGISTRAR'S SIGNATURE Wimfred W. Mosley	370	25. FUNERAL DIRECTOR'S SIGNATURE DeMoss CRUNK	ADDRESS CAMERON MO
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(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 Lawrence J. Thompson

Licensed Embalmer No. 47357

P. O. Address Cameron, 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.

