

FILED MAR 7 1951

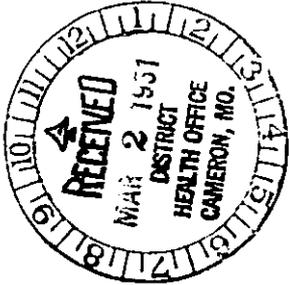
THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5792 State File No. 4105

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 55 PRIMARY REG. DIST. NO. 20 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death.) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural "Combs Sup" Lake</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural "Combs Sup"</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>10 mi. E. of Carrollton</u>		d. STREET ADDRESS (If rural, give location) <u>10 mi. E. of Carrollton</u>	
3. NAME OF DECEASED a. (First) <u>WALTER</u> b. (Middle) <u>WELLS</u> c. (Last) <u>AUDSLEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 21 1951</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 16 1893</u>
9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Frank Audsley</u>		13b. MOTHER'S MAIDEN NAME <u>Ruth Squires</u>	
14. NAME OF HUSBAND OR WIFE <u>Grace Aresbrough</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes World War</u>		16. SOCIAL SECURITY NO. <u>World War</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Walter Audsley, DeWitt Mo.</u>		ADDRESS <u>DeWitt Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Urinary occlusion</u></u> <u>2. ANTECEDENT CAUSES <u>Engel's</u></u> <u>3. OTHER SIGNIFICANT CONDITIONS <u>None</u></u>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>Two hrs.</u>	
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) (Min.)		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>Mar 21, 1951</u> , to <u>Mar 21, 1951</u> , that I last saw the deceased alive on <u>Feb 21, 1951</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>P. Hamilton Huter, M.D.</u>		23b. ADDRESS <u>Carrollton Mo.</u>	
23c. DATE SIGNED <u>Feb 22</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-23-51</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Park</u>		24d. LOCATION (City, town, or county) (State) <u>Carrollton Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2/20/51</u>		REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert Standley</u>	
FUNERAL DIRECTOR'S SIGNATURE <u>W. Gibson</u>		ADDRESS <u>Carrollton Mo.</u>	

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



MAR 7 1951

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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 William R Koch

Licensed Embalmer No. 4751

P. O. Address Carrollton, 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.