

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25232

FILED JUL 17 1953

3187

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2		d. STREET ADDRESS (If rural, give location) 1223 Michigan Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) Gertrude b. (Middle) Walters c. (Last) Walters		4. DATE OF DEATH (Month) (Day) (Year) 6 20 1953	
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed d 3	8. DATE OF BIRTH July 1885
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	10b. KIND OF BUSINESS OR INDUSTRY
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Alex Fisher	13b. MOTHER'S MAIDEN NAME Mary	14. NAME OF HUSBAND OR WIFE Frank Walters
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. 492-26-3922	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Susan Cavans 1126 Virginia

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) Hypertensive Heart Disease with Heart failure. 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 - Chronic Glomerulonephritis. Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 493 1/2
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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) m.	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 3-20-53, 19, to 6-20-53, 19, that I last saw the deceased alive on 6-20-53, 19, and that death occurred at 12:00 a m., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis	(Degree or title) MD	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 6-22-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/24/53	24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Kansas
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DATE REC'D BY LOCAL REG. 6-22-53	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Watkins Bros. 18th & Benton
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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 *Daniel H. Washburn*

Licensed Embalmer No. 4500

P. O. Address 18th & 4th Bosto

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.