

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5110**

FILED FEB 18 1954

BIRTH NO. _____ REG. DIST. NO. 199 PRIMARY REG. DIST. NO. 1002 Registrar's No. 534

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Caldwell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Hamilton	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 9 days		e. STREET ADDRESS (If rural, give location) 0130	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Joseph Hospital			
3. NAME OF DECEASED (Type or Print) LLOYD		a. (First) C.	b. (Middle) WALLING
c. (Last) WALLING		4. DATE OF DEATH (Month) (Day) (Year) Jan. 31, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 7, 1897
9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor	11. BIRTHPLACE (City and State or Foreign Country) Storm Lake, Iowa
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Mo. Power & Light Co.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE Nora Walling
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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Nora Walling, Hamilton, Missouri
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) Pseudo Myxoma Peritonii ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Mucosal Involvement Bladder. DUE TO (c)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION above	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.			
23a. SIGNATURE Russell W. Kerr		23b. ADDRESS St. Joseph Hospital	23c. DATE SIGNED 1-26-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-1-54	24c. NAME OF CEMETERY OR CREMATORY Hamilton, Missouri
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE UND. CO. K.C.MO.		
DATE REC'D BY LOCAL REG. 2-2-54	REGISTRAR'S SIGNATURE Seraldine Smith		

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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.....
Signature of Student Embalmer

Signed.....
J. H. Crowell

Licensed Embalmer No. 496

P. O. Address *J. H. Crowell*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.