

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12267
1595

BIRTH NO. 23316-54 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 OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) Life		e. STREET ADDRESS (If rural, give location) 511 Wabash	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeside Hospital		3109 0	

3. NAME OF DECEASED (Type or Print)	a. (First) DEBORAH	b. (Middle) ANN	c. (Last) Walker	4. DATE OF DEATH (Month) (Day) (Year) April 5, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH APRIL 5-1954	9. AGE (In years last birthday) 6	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT	11. BIRTHPLACE (City and State or Foreign Country) KANSAS CITY MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Lindy Tolbert Walker	13b. MOTHER'S MAIDEN NAME Nellie Rhoads	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS LINDY TOLBERT WALKER 511 WABASH KANSAS CITY 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7544
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital heart lesion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral anoxia. DUE TO (c) Accusian Section		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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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 April 3, 1954, to April 5, 1954, that I last saw the deceased alive on April 5, 1954, and that death occurred at 4:45 Pm., from the causes and on the date stated above.

23a. SIGNATURE S. I. Collier	(Degree or title) M.D.	23b. ADDRESS 14002 E 31st St. PCMO	23c. DATE SIGNED 4/8/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-8-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) HUNTSVILLE, ARKANSAS
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DATE REC'D BY LOCAL REG. 4-8-54	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DW Newsome - Lou Harris City, Mo
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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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 4934
P. O. Address K. C. 10, M.

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.