

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29707

State File No.

No. 300
10-48

FILED SEP 22 1954

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

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>256</u>	
1. PLACE OF DEATH a. COUNTY <u>ADAIR</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>KNOW</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>KIRKSVILLE</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>HURDLAND</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>KIRKSVILLE OSTEOPATHIC</u>				e. STREET ADDRESS (If rural, give location) <u>2 1/2 MI SW HURDLAND 0 5 20 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u>		b. (Middle) <u>ALBERT</u>		c. (Last) <u>WALTERS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 13 1954</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>JULY 13 1866</u>	
9. AGE (In years last birthday) <u>88</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>COLE CITY INDIANA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>MICHAEL WALTERS</u>		13b. MOTHER'S MAIDEN NAME <u>RACHEL M. WADE</u>		14. NAME OF HUSBAND OR WIFE <u>ETTA CUSICK WALTERS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>L</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>OPAL EAGLE BRASHEAR MO</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Medullary Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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) <u>332X</u>			
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 <u>8-31</u> , 19 <u>54</u> , to <u>9-13</u> , 19 <u>54</u> that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>David W. Brase MD</u> (Name or title)				23b. ADDRESS <u>Kirkville MO</u>		23c. DATE SIGNED <u>9-14-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>9/15 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>BRASHEAR</u>		24d. LOCATION (City, town, or county) (State) <u>BRASHEAR MO</u>	
DATE REC'D BY LOCAL REG. <u>9-16-54</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FEDERAL REGISTRAR'S SIGNATURE ADDRESS <u>Dr. B. Casey, Hurdland MO</u>			

(Licensed Embalmer's Statement on Reverse Side)

NOV 16 1957

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 *Geo H. H. H. H.*

Licensed Embalmer No. *3753*

P. O. Address *Fordland*

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.